Eltham Palace PMS

Quality Report

Eltham Palace PMS
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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 Eltham Palace PMS on 11 December 2014. 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 is rated as requires improvement for providing safe services. While staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses, clinical staff had not undertaken relevant child protection training.

It was also good for providing services for older people; people in the working age populations and those recently retired and people experiencing poor mental health. We found that requirements were required for families, children and young people and people whose circumstances may make them vulnerable

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.

• Risks to patients were assessed and well managed.

• 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 they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand.

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

Summary of findings

• 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.

However, there are also area(s) where the provider must make improvements

- Ensure that all staff have undertaken relevant child protection training.

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, appropriately reviewed and addressed. Risks to patients were assessed and well managed. However not all clinical staff had undertaken relevant child protection training.

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. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. 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 had received training appropriate to their roles and further training needs have been identified and planned. The practice had completed all appraisals and the personal development plans for all staff. There was evidence of multidisciplinary working with other health and social care professionals.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of care. Patients we spoke with on the day of the visit 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 care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

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 their NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, having a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was

Summary of findings

well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating 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 well-led. The practice had a clear vision, and a strategy to deliver it. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively 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, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. All patients aged 75 and over had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of direct enhanced services that were designed to reduce hospital admissions. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The GPs followed up all patients discharged from hospital within 24 hours to check they had all the medicines required.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk, such as those, who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. There were baby change facilities, space for prams and buggies and a play area. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and urgent referrals made for children and pregnant women who had a sudden deterioration in health. However a member of the medical team had not completed role specific child protection training.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and this included patients with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and 100% of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). 62% of people experiencing poor mental health had received an annual physical health check. The practice told us they had scored slightly low in this area due to the number of patients moving addresses and not notifying them. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice offered these patients opportunistic cervical smear checks, flu vaccinations and other health and well-being checks.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND and SANE. The practice had a system in place to

Summary of findings

follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for patients with mental health needs and patients with dementia.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection and received 26 completed comments cards.

Patients reported being happy with the care and treatment they received. All patients we spoke with were complimentary on the attitudes of all staff and reported feeling well cared for and respected.

The patients we spoke with had not made a complaint, they were aware of the process and said they would speak with the practice manager and felt confident that their issues would be addressed.

Patients said they were treated appropriately and staff maintained their privacy and dignity. We saw staff spoke politely to patients. Patients said they were involved in decisions about their care and treatment.

The results of the national patient survey 2014 showed the practice scored the same as the national average at 91% for the proportion of respondents who rated their GP surgery as 'good' or 'very good' and in the top range for the proportion of patients who would recommend their GP practice.

Areas for improvement

Action the service MUST take to improve

Ensure that all staff have undertaken relevant child protection training.

Eltham Palace PMS

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP specialist advisor.

Background to Eltham Palace PMS

Eltham Palace PMS also known as Eltham Practice Surgery is based in the London Borough of Greenwich. The practice provides primary care services to 4800 patients.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostics and screening procedures; family planning; maternity and midwifery services; and treatment of disease, disorder or injury.

The practice is located in an area that has high deprivation as well as pockets of affluence The practice serves a culturally diverse population, including British, African, Caribbean, White Other, Indian and Chinese patients. According to the practice they have a high number of young and elderly patients.

The practice has two GP partners, female and male , plus one salaried male GP. The practice employs one practice nurse and one advanced nurse practitioner. A healthcare assistant is also available for 35 hours per week and eight administrative staff and the practice manager.

The practice holds a Personal Medical Services (PMS) contract for the delivery of general medical services. Personal Medical Services (PMS) agreements are locally agreed contracts between NHS England and a GP practice. PMS contracts offer local flexibility compared to the nationally negotiated General Medical Services (GMS) contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).

Appointments were available from 08:00 am to 18:30 pm on weekdays. Extended hours were offered on Tuesdays & Wednesday mornings 07:00- 08:00am and Tuesday evening 18:30-19:30pm.

The practice has opted out of providing out-of-hours services to their own patients. A local out of hours service, 111, is used to cover emergencies.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

Detailed findings

- 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 we hold about the practice and asked other organisations such as Healthwatch, NHS England and the Clinical Commissioning Group (CCG) to share with us what they knew. The practice is on Band 5 of GP intelligent monitoring. The Bands range from 1-6, with 1 being a high priority for inspection. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. We carried out an announced visit on 11 December 2014. During our visit we spoke with a range of staff including GPs, practice manager, practice nurse and administrative staff, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We received 26 completed patient comments cards.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. These included for example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed the safety records, incident reports and minutes of meetings for the last three year period where these were discussed. This showed the practice had managed these consistently over time and so could evidence 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. Records were kept of significant events that had occurred during the 12 months and these were made available to us. There was evidence that appropriate learning had taken place and that the findings were shared with relevant staff.

Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at practice meetings and felt encouraged to do so. All staff we spoke with told us that incidents were reported to the practice manager as soon as possible and a written account of the incident was recorded in the incident record book. Examples of incidents that we noted included administrative errors on recording patient details. Another example was that of a patient referral that was faxed to the heart failure clinic. The practice had documented that the fax had been sent. However the patient informed them that they had still not received an appointment. When the practice made a follow up they were advised that the referral had not been received. The practice recognised that this had delayed the patient's specialist appointment and following this they had introduced a system to ensure that all referrals faxed were followed up instantly to ensure they had been received. We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to ensure these were managed and monitored. We tracked one incident and saw records were completed in a comprehensive and timely manner and that action was taken as a result.

National patient safety alerts were disseminated by the practice manager to practice staff. A dedicated GP was also nominated, who advised of the required actions following any such alerts. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. One such example involved the national withdrawal of a certain medicine. The alert was passed onto the nominated GP. The GP was able to identify patients who were affected and follow up appointments were booked with the recommended alternative medicine being prescribed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that the majority of staff had received relevant role specific training on safeguarding. Two GPs at the practice had received Level 3 child protection training; however a recently recruited GP had not received any child protection training. The practice advised that this training was due to be delivered shortly. The practice nurses had received Level 2 child protection training and reception and administration staff had all received Level 1 training.

All staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We noted that the contact details were easily accessible.

The practice had a dedicated GPs appointed as leads in safeguarding vulnerable adults and children who had been trained and could demonstrate they had the necessary competencies 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.

Requires improvement

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments such as those for Looked After Children (LAC) who required additional monitoring.

A chaperone policy was in place and on display 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 professionals during a medical examination or procedure). Chaperone training had been undertaken by all nursing staff, including health care assistants. All receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. All staff acting as chaperones had been DBS checked.

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

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of any potential failures. The policy was being followed by the practice staff, who were able to confirm to us the actions they would take to address any failures to maintain medicines at the right temperatures. We saw records that confirmed the fridge temperatures were checked and recorded. All recordings for the past 12 months were within the required range.

Systems were in place to check medicines were within their expiry date and suitable for use. A check list was available and the practice nurse used this to ensure all checks were accurate. However we found that adrenaline medicines had expired a few days before our inspection in one of the emergency kits kept at the practice. Staff were aware of this. When we pointed this to staff they advised that there had been a delay in receiving new stocks. However they had an emergency kit that was shared and were able to show this to us as well new kit that arrived on our inspection day. All other 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 nurses using current directives that had been produced in line with legal requirements and national guidance. We saw a copy of directives from the Clinical Commissioning Group (CCG) and evidence that nurses had received appropriate training to administer vaccines. All vaccination batch numbers were recorded in the patient records including the Red Book for children to ensure that if an alert was raised on the vaccine they could easily identify patients who had been affected.

The practice had in place a protocol for repeat prescribing which was in line with national guidance. Patients could request repeat prescriptions online and in writing. 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. A local pharmacist was also part of the practice team. Their role was to carry out medicines audits and ensure that the practice was working within the requirements of the local CCG. The pharmacist was also responsible for providing guidance to clinical staff on medicines interactions and also provided an anticoagulant consultation clinic

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 practice 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 there after annual updates. We saw evidence the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

Requires improvement

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

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

The practice had a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice had carried out a risk assessment that had identified a low risk. This risk assessment was continuously updated.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence that calibration of relevant equipment had been completed in October 2014.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. 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 via the Disclosure and Barring Service.

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 they were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts which we viewed.

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

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 as an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an incident of a missing referral and this had resulted in them changing the referral policy to minimise risk of patients receiving treatment late.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.). All staff we asked knew the location of this equipment, and records we saw confirmed these were checked regularly

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 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

Requires improvement

Are services safe?

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 such as the, contact details of a heating company to contact in the event of failure of the heating system. The practice had also partnered with other practices in the local area to support each other in times of such event should there be the need.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. The practice had an appointed fire lead who took responsibility in sharing guidance and undertook mock testing to ensure all staff were aware of the policies and procedures.

Risks associated with service and staffing changes (both planned and unplanned) were noted on the practice risk log and possible action identified beforehand.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs reviewed incoming guidelines such as those from the National Institute for Health and Care Excellence (NICE) and peer-reviewed journals such as the British Medical Journal (BMJ) and where considered relevant they were discussed in practice clinical meetings and by e-mails. There was evidence of a good working relationship between the professionals to ensure information was cascaded suitably and adapted accordingly. We saw minutes of practice meetings where new guidelines were shared, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

We found that GPs lead in specialist clinical areas such as mental health, diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders including asthma. The practice held a clinical meeting once every month and the review of the clinical meeting minutes confirmed this happened.

National data showed 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 patients. Patients with suspected cancers were referred and seen within two weeks. The practice had an appointed administrative staff who followed up these referrals to ensure patient's treatment was not delayed. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practise were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

The practice had systems in place to monitor and manage outcomes to help provide improved care. GPs and the practice manager were actively involved in ensuring important aspects of care delivery such as significant incidents recording, child protection alerts management, referrals and medicines management were being undertaken suitably.

Medicines and repeat prescriptions were issued based on nationally accepted guidelines. The senior GP partner showed us data from the local CCG of the practice's performance for benzodiazepine prescribing had significantly lowered and this was in line with other practices in the CCG.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required them to be reviewed within two weeks by their GP according to need.

Regular clinical meetings took place with multi-disciplinary attendance to ensure learning and to share information. There was evidence from review of care that patients with dementia, learning disabilities and those with mental health disorders received suitable care with an annual review of their health and care plan.

The practice had completed clinical audits. The main audit on benzodiazepines use had been completed in July 2014. The purpose of the audit was to review the safe and effective prescribing of benzodiazepines, ensuring that patients prescribed a benzodiazepine or Z-drug have a clear indication recorded in their records and that all patients prescribed a benzodiazepine or Z-drug have been given appropriate advice on the risks, including the potential for dependence and that the medicines are reviewed regularly ideally monthly. The audit found that; prescribing data available from Prescription Pricing Authority indicated a decrease in prescribing volume of benzodiazepine at the practice for the last three quarters.

Good

Are services effective?

(for example, treatment is effective)

The audit identified areas for improvement, formulated an action plan to optimise prescribing and agreed to prescribe non-benzodiazepines drugs e.g. antihistamine and melatonin as first-line therapy for insomnia. The audit also resulted in the practice referring patients with difficulty in managing anxiety to the assessment and shared care team at Oxleas which is the local mental health trust for assessment and a personal care plan. The practice planned to re- audit in six months.

Effective staff

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. A good skill mix was noted amongst the doctors with some having diplomas in children`s health, obstetric care and mental health care. All GPs were up to date with their yearly continuing professional development requirements with revalidation in 2016 and 2017 respectively. (Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation.)

The practice had records supplied by the practice nurses that showed their registration with the Nursing and Midwifery Council (NMC) was current. The practice had also verified these records.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, such as travel vaccines and asthma management and customer service training. They held in-house training days where guest speakers and trainers attended.

Practice nurses and the nurse practitioner had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, they had received training in administration of vaccines, and in performing cervical cytology. Those with extended roles such as independent nurse prescribing were also able to demonstrate they had appropriate training to fulfil these roles. The nurses were also part of a local cluster that shared information and developments in clinical updates.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, and communications from the out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in reading, passing on and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing 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 within the last year of any results or discharge summaries which were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients such as those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, the integrated community team, and the COPD team. 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 out of hours provider to enable patient data to be shared in a secure and timely manner. For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of

Good

Are services effective?

(for example, treatment is effective)

this communication with A&E. The practice also had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff 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 requirements of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. Eight clinical notes we reviewed confirmed this. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.)

Health Promotion & 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.

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

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and they were offered an annual physical health check. Practice records showed that all patients with learning disabilities had received a physical health check in the last 12 months.

The practice's performance for cervical smear uptake was 63% for the 2013 /2014 period which was better than other practices in the CCG. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following-up patients who did not attend screening.

The practice offered a full range of immunisations for children, adults and travel, in line with current national guidance. The practice's performance on childhood immunisations for children aged three months to 12 months were as follows; Dtap/IPV/Hib 74%,Men C and PCV 74%,Hep B 74% and MMR 86% was all of which were above the CCG average for the CCG.

The practice offered patients a variety of health promotion leaflets. The practice nurse offered a range of health promotion clinics, including child immunisations, travel information and vaccinations, chronic disease management for asthma, diabetes, epilepsy, and HIV. Due to the high prevalence of diabetes and stroke in the local area, additional clinics were run by the nurses to manage these conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The evidence from all these sources showed patients were generally satisfied with their GP practice. The results of the national patient survey 2014 showed the practice scored the same as the national average at 91% for the proportion of respondents who rated their GP surgery as 'good' or 'very good' and in the top range for the proportion of patients who would recommend their GP practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 26 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect We also spoke with five 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us 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 she 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 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 responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 national patient survey showed 87 % of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area.

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.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Staff told us families who had suffered bereavement received a phone call by their GP. This call was either followed by a consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke had never needed this support but were aware that bereavement support was available if needed.

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations such as the housing team or the citizen's

Good

Are services caring?

advice bureau. 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.

During patient registration the practice noted down details of carers. This was to ensure they were offered all support and information relating to patient and carer support information. 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the needs of the practice population were understood and systems were in place to address identified needs. The practice used a locally devised risk tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The 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. One of the senior GPs at the practice was a project lead for the CCG. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. There had been very little turnover of staff during the last 10 years which enabled good continuity of care and accessibility to appointments with a GP of choice. The practice had a mix of female and male GPs .This gave patients choice of being seen by a preferred GP.

Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who were too ill to attend the practice or those with mobility difficulties. Flu vaccinations were also offered at home for those patients who were too ill to come to the practice.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment Information for those patients that had attended services such as, out of hours, accident and emergency and other hospitals was shared electronically. A system was in place that scanned these records onto individual patient records to ensure continuity of care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The

practice was aware of the needs of the elderly population as well as local teenage mothers. As a result the practice recognised the need to support patients in dealing with other agencies such as social services and housing as well as the local health visiting and children's services. The practice proactively followed up on children who missed their childhood immunisations and GP appointments and this information was passed to the relevant local teams.

The practice offered patient registrations and opportunistic appointments to homeless patients. They also had a system in place for flagging these patients. Staff told us that they prioritised appointments for vulnerable patients to reduce the likelihood of a missed opportunity in providing them access to healthcare.

The practice offered emergency appointments to parents of school age children. Services such as child vaccinations, cervical screening and well man and woman checks were offered during evening extended hours, as well as during regular hours. This enabled the working population or those not able to attend during the normal working hours the same access.

The practice had access to online and telephone translation services for patients who spoke other languages.

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

Access to the service

Appointments were available from 08:30 am to 18:30 pm on weekdays. Extended hours were offered on Tuesdays and Wednesday mornings from 07:00-08:00 and 18:30 until 19:30 pm on Tuesdays evenings. These appointments were particularly useful to patients with work commitments.

Comprehensive information was available to patients about appointments on the practice website. This included how to get help in emergency, request home visits, getting test results, changing address, accessing medical records and how to book and cancel appointments through the website. Information was also available on the various services available at the practice. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called

Good

Are services responsive to people's needs?

(for example, to feedback?)

the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

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

The practice was situated over a number of floors. Staff and patients all confirmed that patients who had difficulties climbing stairs could be seen on the ground floor. 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 including baby changing facilities.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and 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 .This was included in the practice information leaflet and displayed in the reception area and on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at the record of complaints and found that ten formal complaints had been received in the last 12 months. All complaints had been dealt with in a timely manner and had been resolved.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review in 2013 and found that lessons learnt from individual complaints had been acted upon. The practice welcomed comments from patients. These were via a suggestion box. Staff told us this was checked monthly and common themes were feedback in meetings with solutions. Meeting minutes we saw confirmed this.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG contained representatives from various population groups; including the retired and working age population. They told us that they had not conducted any surveys but felt the practice listened to suggestions they made.

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 business plan. These values were clearly displayed in the waiting area and in the staff room. The practice vision and values included offering a friendly, caring good quality service that was accessible to all patients.

We spoke with seven 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 the practice meetings and saw that staff discussed and shared the values on a regular basis to ensure they all worked towards them. All staff we spoke with knew and understood 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 via the desktop on any computer within the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. For the period 2013/2014 the practice had achieved 752 points out of 900. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits, including on the use of Benzodiazepines. As a result of this audit the non-essential prescribing had lowered and the practice was referring alternative therapy.

The practice had arrangements for identifying, recording and managing risks. An emergency plan had been drafted and all staff were aware of the procedure to follow. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. We saw that the practice had protocols that reception staff followed to ensure patients that had infectious conditions were isolated as soon as they attended the practice to avoid risk of cross infections. The practice had also identified risk of non –essential prescribing and as result they had employed a pharmacist to conduct regular audits which were shared with staff and advice on drug interactions was always at hand.

Leadership, openness and transparency

We were shown a clear leadership structure which had 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. The practice manager was the lead for all administrative and managerial issues. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. 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 saw that the practice welcomed views from all the staff and as such there was collective responsibility when making decisions and staff felt involved and valued.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, training, and the management of sickness which were in place to support staff. We were shown a staff handbook that was available to all staff, these included sections on equality and harassment and bullying at work. 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 an active patient participation group (PPG) which had steadily increased in size. Findings from PPG surveys and information on how to be involved with the PPG was shared with patients via a newsletter or on the practice website. The PPG contained representatives from various population groups; including the retired and some ethnic minority patients. The PPG had carried out yearly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG.

Are services well-led?

Good

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

The practice had a whistle blowing 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 them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that all staff had a personal development plan and annual appraisals took place. Staff told us that the practice was very supportive of training. The practice had completed reviews of significant events and other incidents and shared with staff via meetings.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person failed to ensure that one of the GPs had received appropriate child safeguarding training.**