Dr Christopher Anthony Grainger Stern

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Christopher Anthony Grainger Stern also known as Carepoint Practice on 7 April 2015.

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

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.
- There were processes in place to safeguard vulnerable adults and children.
- Patients' needs were assessed and care was delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned through personal development plans.
- Patients said they were treated with kindness, care and respect and they were involved in decisions about their care and treatment.
- Patients were generally satisfied with the appointment system and found it easy to make an appointment.
- Staff felt that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.

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

The provider should:

- Review the refrigerator temperature monitoring record log to ensure that all relevant data is captured and that dates of checks are recorded.
- Review the child protection policy to ensure that the information is up to date.

Summary of findings

- Ensure that information about the practice opening hours is consistent in the literature available to patients.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Significant events were discussed as a standing agenda item at practice meetings to share learning and improve services. There was a lead for safeguarding and staff had received safeguarding vulnerable adults and child protection training appropriate to their role. The practice had an infection control policy and conducted regular audit to ensure this was followed and to make improvements were necessary. Emergency equipment was available and checked regular to allow staff to manage medical emergencies.

Are services effective?

Good

The practice is rated as good for providing effective services. Clinical staff were aware of and completed thorough assessments of patients' needs in line with guidance from National Institute for Health and Care Excellence. The practice conducted regular clinical audit to monitor performance and improve outcomes for patients. Staff had received training appropriate to their roles and any further training needs had been identified through personal development plans reviewed and updated at annual appraisal. The practice held monthly multi-disciplinary team meetings attended by district nurses and palliative care team to discuss and plan the needs of patients with complex medical problems. The practice had a mechanism in place to promote good health in their practice population including new patient health checks and in house smoking cessation clinics with access to lung function testing. Uptake rates for immunisations were at or above the national average and there was a clear policy to follow up on non-attenders.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with kindness, care and respect and they were involved in decisions about their care and treatment. Results from the national GP patient survey published in January 2015 showed 83% of respondents described their overall experience of the practice as good and this was above the average score for the CCG area. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS England and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had access to telephone translation services and some of the clinical staff could speak two languages which assisted patients who did not have English as their first language. The practice was accessible to wheelchair users. Same day urgent appointments and telephone consultations were available and there was the facility to book routine appointments online. Patients we spoke with were generally satisfied with the appointment system and satisfaction scores on appointments from the national GP patient survey were above average for the CCG area. Information about how to complain was available and easy to understand. Complaints were reviewed annually to identify any themes and trends.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision to provide better care to patients through empowering staff and patients to take joint responsibility in health care. Staff understood their responsibilities in relation to this and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held monthly practice meetings to discuss governance issues. The practice sought feedback from patients through annual surveys and the Friends and Family Test (FFT). The most recent results of the FFT showed 94% of respondents would recommend the practice to others. The Patient Participation Group (PPG) was active and produced a newsletter three times a year to update patients on practice news and promote services offered by the practice. There was evidence the practice made improvements to service as a result of feedback from the PPG.

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. All patients over the age of 75 years had a named GP to co-ordinate their care and they were invited to annual health checks. Health checks were conducted during home visits if patients were unable to attend the practice due to illness or immobility. The practice used a risk stratification tool to identify patients over 75 years at risk of an unplanned hospital admission and invited them to receive personalised care planning to improve their health and well-being. The practice held monthly multidisciplinary meetings to discuss patients with complex needs including elderly and frail patients and those with end of life care needs. The practice offered a full range of immunisations in line with national guidance and flu immunisation in patients over 65 years of age was high.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients with long term conditions were invited to annual nurse-led medical reviews and there was a system in place to alert staff when these reviews were due. Reminder letters were sent to patients inviting them to attend for annual review. Regular searches were performed to identify patients that required improvements to their long term conditions. The practice used risk stratification tools to identify patients at risk of hospital admission and they had a programme to create integrated care plans to help manage and meet these patients' needs. The practice offered flu immunisation to at risk groups of patients in line with national guidance and uptake rates were high.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There was a named lead for safeguarding and safeguarding alerts were placed on patient's electronic records to alert staff to any child protection plans in place when they attended appointments. The practice offered the full range of childhood immunisations and uptake rates were at or better than the CCG average for the local area. There was a system to follow up patients who did not attend immunisation appointments. There were nurse-led women's health clinics providing cervical smears, family planning and sexual health advice. All women were encouraged to

Summary of findings

attend for regular cervical smear testing and the practice had a reminder system for patients who did not attend. A well-baby clinic and developmental check led by community health visitors was held at the practice weekly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). Extended hour opening was available for bookable appointments from 7.30am on Mondays, Tuesdays, Thursdays and Fridays for patients unable to attend the practice during normal working hours. The practice offered same day emergency appointments and telephone consultations with GPs could also be requested on the same day. Repeat prescriptions and appointments could be made online for those who found it difficult to attend the practice. The practice offered NHS Health Checks to patients aged 40 -75 years. The practice identified the smoking status of patients over the age of 16 and offered a nurse led smoking cessation service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. There were alerts added to patient notes to make staff aware of any specific requirements and extended appointments could be offered to patients who required translation services. The practice kept a register of patients with learning disabilities and offered them annual health checks including medication review and blood tests. One of the lead GPs had received training in managing patients with drug and alcohol misuse problems and these patients were referred to local hospital drug and alcohol teams for continued support when needed. Patients could be referred to see a counsellor on site for advice on alcohol and drug-related problems.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health were offered annual health checks with a care plan review. The practice offered screening for memory problems during routine consultations and referred on to memory services if required. The practice had an experienced clinical lead for dementia. They had a register of patients diagnosed with dementia and arranged annual health reviews of these patients.

Summary of findings

What people who use the service say

During our inspection we received six Care Quality Commission (CQC) comment cards that patients had completed and spoke with nine patients, four carers and two members of the patient participation group (PPG). Overall the feedback given was positive. The majority of patients were satisfied with the care they received and felt that all staff at the practice were helpful, kind and caring. This was similar to the findings of the national GP patient survey published in January 2015 which found that 83% of respondents described their overall experience of the practice as good and 75% described their experience of making an appointment as good. These results were above the local Clinical Commissioning Group (CCG) average for the area.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Review the refrigerator temperature monitoring record log to ensure that all relevant data is captured including temperature range and dates when checks are made.
- Review the child protection policy to ensure that the information is up to date.
- Ensure that information about the practice opening hours is consistent in the literature available to patients.

Dr Christopher Anthony Grainger Stern

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and expert by experience who were granted the same authority to enter the practice premises as the CQC inspector.

Background to Dr Christopher Anthony Grainger Stern

Dr Christopher Anthony Grainger Stern, also known as Carepoint Practice, provides primary medical services for patients in the Hillingdon and Uxbridge area within the London Borough of Hillingdon. It is part of the NHS Hillingdon Clinical Commissioning Group (CCG) which is made up of 48 GP practices. The practice holds a core General Medical Services (GMS) contract and provides primary medical services to approximately 5,000 registered patients. The practice is currently managing an additional 3,000 patients due to the recent closure of a GP practice operating from the same premises until a formal merger is overseen by NHS England.

The practice team comprises of one male GP partner, one male salaried GP, two part-time female locum GPs, one part time male locum GP, two female practice nurses, one female health care assistant, two pharmacists, a practice manager, a secretary and six receptionists. One of the practice nurses is a registered nurse prescriber.

The practice opening hours are 7.30 am to 6.30 pm on Mondays, Tuesdays and Fridays; 8.00am to 6.30 on Wednesdays; and 7.30am to 4.30pm on Thursdays. Appointments are available from 7.30am to 8.00am; 8.30am to 12.10pm and 3.00pm to 6.00pm on Mondays, Tuesdays and Fridays; 8.30am to 12.10pm and 3.00pm to 6.00pm on Wednesdays; 7.30am to 8.00am and 8.30am to 12.10pm on Thursdays.

Out of hours services are provided by a local provider. The details of the out of hours service are communicated in a recorded message accessed by calling the practice when it is closed and on the practice website.

The practice provides a wide range of services including checks for diabetes, asthma review, family planning services, minor surgery and child health care. The practice also provides health promotion services including a flu vaccination programme, smoking cessation clinic and cervical screening.

The age range of patients is predominately 25-64 years and the number of 25-39 year olds is greater than the England average. There is a wide distribution of social and ethnic backgrounds in the practice patient population.

The practice has previously been inspected during our pilot phase in September 2014 and shortfalls were found relating to the arrangements in place for managing complaints and with the storage of patient's paper based records.

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

Detailed findings

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.

The practice had previously been inspected by the Care Quality Commission on 1 September 2014. This was part of the pilot phase of the CQC's new methodology and as a result the practice did not receive a rating. They were in breach of Regulation 19 (2)(a)(b) and Regulation 20 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 so we have re-inspected this location to check that improvements have been made and to give the practice a rating for the services they provide. Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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 to share what they knew. We met with NHS England, NHS Hillingdon Clinical Commissioning Group (CCG) and Healthwatch Hillingdon and reviewed the information they provided us with. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 7th April 2015.

During our visit we spoke with a range of staff including GPs, practice manager, practice nurses and reception staff. We also spoke with nine patients who used the service, four carers and two representatives from the practice patient participation group (PPG). We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed policies and procedures, practice maintenance records, infection control audits, clinical audits, significant event records, staff recruitment and training records, meeting minutes and complaints We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed six Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the days before our visit.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, an incident had been recently reported when a vaccination had been dispensed incorrectly by the pharmacy. The GP noticed the error before the vaccine had been administered and alerted the pharmacy about the issue who conducted an investigation into what had occurred. This significant event was discussed at the practice meeting to highlight the importance of clinical staff checking vaccinations before administering to patients.

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

Learning and improvement from safety incidents

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

Staff used incident forms on the practice intranet to record significant events. Information recorded on these forms included a description of the event, positive points, areas for concern, suggestions for improvement and actions to be taken and by whom. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example an incident when a patient had been prescribed the incorrect medication but the patient did not receive it was discussed at the practice meeting to raise awareness and provide education on using the electronic prescribing system when prescribing medicines with similar names. We noted that another significant event that was reported referred to a positive incident that had occurred. The review in this case highlighted the notable actions that had been taken by staff as a point of learning for the whole practice.

National patient safety alerts were disseminated electronically 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.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a safeguarding vulnerable adults policy and child protection protocol available for staff to refer to. However we noted the child protection policy was last reviewed November 2010. We looked at training records which showed that all staff had received relevant role specific training on safeguarding, for example clinical staff had received child protection training to level thee and non-clinical staff to level one. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for the Clinical Commissioning Group (CCG) safeguarding lead were available.

The GP partner was the practice lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. We saw safeguarding cases were discussed at the monthly practice meeting.

Good

Are services safe?

The practice had a chaperone policy which was visible on the reception desk window and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Reception staff would act as a chaperone if nursing staff were not available and records confirmed that they had undertaken chaperone training in 2014. Reception staff we spoke with understood their responsibilities when acting as chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures. Staff we spoke with were aware of what to do if the temperature fell outside the required range of two and eight degrees. A daily refrigerator temperature log was maintained however, we observed that this did not document the daily minimum and maximum temperature recordings. The temperature log record was also combined with vaccine weekly stock check log, neither of which were signed or dated.

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, with the exception of one vaccination with an expiry date of 31 March 2015. We were told that this would have been picked up during the weekly stock check but this had yet to be completed at the time of inspection. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We were shown up to date sets of PGD's. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescribing GP. We saw evidence that nurses and the health care assistant had received appropriate training to administer the medicines referred to in both the PGDs and PSDs. A member of the nursing staff was qualified as an independent prescriber.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning services were provided by an external company contracted by NHS Property Services who were the landlords of the practice premises. Comprehensive cleaning schedules were in place and cleaning records were maintained. We saw records to confirm that monthly audits were conducted by the cleaning contractor and landlord to assess compliance against the national standards for cleanliness in the NHS. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was lead for infection control. The health care assistant was responsible for the weekly monitoring and cleaning of clinical equipment and had completed infection control training in the last year. The practice had carried out an infection control audit in December 2013 and that this had been reviewed and updated with improvement actions completed between January 2014 and April 2014. A further annual audit was completed in December 2014 and no remedial actions were identified.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle-stick injury and staff knew the procedure to follow in the event of an injury.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and notices about hand washing techniques were displayed around the practice.

The landlords of the practice premises were responsible for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). A specialist company had been contracted to carry out Legionella checks and the last survey had been completed. We saw the report of the latest survey completed in July 2012. Clinical waste was stored appropriately and a contract was in place for its collection and disposal.

Good

Are services safe?

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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, oximeters, blood pressure measuring devices, nebulisers and fridge thermometers. The next checks were due in February 2016.

Staffing and recruitment

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

New staff working at the practice received induction training that involved reading the practice policies and procedures. There was a locum GP induction pack given to all locum doctors working at the practice that included information on appointment protocol, antibiotic prescribing guidelines, medication review guidelines, immunisation schedules and contact information for local hospitals and pharmacies.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were enough staff on duty to keep patients safe. The practice manager informed us that staffing levels and skill mix were currently under review, as they were managing additional patients and staff due to the recent closure of a neighbour GP practice.

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 environment, medicines management, staffing, dealing with emergencies and equipment. Building checks and maintenance were carried out by NHS Property Services who were the landlords of the premises. These included a health and safety risk assessment of the workplace in May 2014, a fire risk assessment in April 2015 and an asbestos survey in 2013.

During our previous inspection at the practice on 1 September 2014 we found shortfalls with the storage of patient's paper based records. The records were filed in open shelves behind the reception desk in an area shared with two other GP practices. Risk assessments had not been completed for the way records were stored. During this inspection we were advised that secure storage had been sourced and purchased to mitigate the risks.

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. The defibrillator had been calibrated in October 2015.

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 (allergic reaction), hypoglycaemia (low blood sugar), seizures, infection and chest pain. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice had algorithms for the management of adult resuscitation, paediatric resuscitation, adult choking, paediatric choking, anaphylaxis and meningitis that were available for staff to refer to in an emergency.

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.

Regular fire risk assessments had been undertaken that included actions required to maintaining fire safety. Records showed that staff were up to date with fire training

Good

Are services safe?

and that they practised six monthly fire drills with the most recent in March 2015. Fire alarms were tested weekly and fire alarm maintenance was performed every three months. Fire extinguishers were checked annually with the last check in July 2014.

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 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 practice had a GP lead for clinical updates whose role included updating clinicians about new or changed guidelines. We saw there was a shared drive on the computer system where staff could access up to date clinical guidance.

The GPs had special interests in specific clinical areas such as diabetes, child health, chronic disease management and family planning. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice followed Clinical Commissioning Group (CCG) guidelines for antibiotic prescribing and we saw all clinical staff had ready access to these guidelines on the practice computer system. We were shown data from the local CCG on the practice's performance for accident and emergency attendances and referral rates to secondary care and these were lower than the CCG average. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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 practice showed us several clinical audits that had been undertaken in the last two years. They had conducted a complete second cycle audit into the prescription and regular review of nutritional supplements. As a result of this audit patients prescribed nutritional supplements without a documented indication for on-going treatment, were invited for review and a decision was made to stop or continue the supplements. Two other audits were linked to the quality and outcomes framework (QOF) data from patients with diabetes and Chronic Obstructive Pulmonary Disease (COPD). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice had reviewed the records of patients with diabetes and COPD and highlighted those that required routine checks performing and contacted them to attend for review. As a result of this audit the practice found their percentage achieved against QOF targets for these conditions, had improved.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease, high blood pressure, stroke, heart failure, dementia, depression, mental health and palliative care. This practice was not an outlier for any QOF or other national clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. The practice employed two pharmacists who regularly reviewed acute repeat prescriptions that patients received. They also monitored that the latest prescribing guidance was being used for the management of patients with long term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice maintained a palliative care register and had regular multidisciplinary meetings with the palliative care team to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area in prescribing and emergency admissions.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice used an external online training course resource for practice 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. All GPs were up to date with their yearly continuing professional development requirements and all had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and family planning. Those with extended roles such as managing patients with long term conditions, smoking cessation advice and nurse prescribing, were also able to demonstrate that they had appropriate training to fulfil these roles. The practice had procedures in place to identify and manage poor performance.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service electronically, by post and by fax. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors and palliative care nurses.

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, for example the practice used the Choose and Book system to make referrals to secondary care. (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).

The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system. 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

The clinical staff we spoke with were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients 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 and the practice had completed 83% of care plan reviews for patients with dementia at the time of our inspection. Clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. All minor surgical procedures were performed by a consultant surgeon from a local hospital and patient's written consent was documented in a consent form with a record of the relevant risks, benefits and complications of the procedure.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

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

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were told by clinical staff that any abnormal results found at these health checks would be followed up on promptly by one of the GPs.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and of the eight patients on the register all had been offered annual health checks within the last 12 months. The practice had also identified the smoking status of 83% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics with lung function testing to these patients.

The practice's performance for cervical smear uptake was 84.5%, which was better than the national average. The practice had a policy to follow up on patients who did not attend for cervical smear or immunisation appointments. The practice nurse would telephone patients who had not attended in the first instance and then a letter would be sent reminding the patient to attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The uptake rate for childhood immunisations last year was 85% - 93% at 12 months, 88% - 95% at 24 months and 86% - 91% at five years depending on vaccination. These figures were at or above average for the CCG area. The uptake rate for flu immunisation in patients over 65 years of age was 73% and 50% in high risk patients under 65 years, which were both in line with the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, caring, and compassionate towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that the staff were good and that they were treated with kindness, confidentiality and respect. Many of the completed Care Quality Commission (CQC) comment cards we received referred to staff as kind, caring and helpful.

Evidence from the latest GP national patient survey published by NHS England January 2015 with 117 respondents (347 surveys sent out) showed that patients were satisfied with how they were treated. Seventy-one said that the last GP they saw or spoke to was good at treating them with care and concern and 84% found the receptionists at the practice helpful. Eighty-three of respondents described their overall experience of the practice as good and this was above the average score for the Clinical Commissioning Group (CCG) area.

The practice had a chaperone policy and information about chaperoning was displayed in consulting rooms. Patients had the option to see a male or female GP when booking an appointment. The practice had a patient dignity policy that set standards for staff to follow in order to maintain respect and patient's dignity. These policies were available on the intranet for all staff to access.

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 room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There was a room available if patients wanted to discuss something away from the reception area.

Care planning and involvement in decisions about care and treatment

The results of the GP national patient survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 73% felt the last GP they saw or spoke to was good at explaining treatment and results and 78% said the last GP they saw was good at listening to them. Eighty-five of respondents said the last nurse they saw was good at explaining treatment and results and 75% said the last nurse they saw was good at involving them in decisions about their care.

Patients we spoke with during our inspection told us they felt involved in decision making about the care and treatment they received. They also told us the GPs explained results and treatment options well and provided sufficient information for them to make informed decisions about their care. Patient feedback on CQC comment cards we received said the clinical staff were good at listening to them.

Staff told us that a telephone translation service was available for patients who did not speak English as their first language and was used to involve patients in decisions about their health care and to obtain informed consent. Posters informing patients about this service were displayed around the practice.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. Information in the waiting room and on the practice website sign-posted patients to a number of external support groups and organisations.

The practice kept a register of patients who were carers, including those under the age of 18 years. The practice computer system alerted GPs if a patient was a carer. We saw written information available in the waiting room for carers to raise awareness of support available to them, such as information about external training courses available.

Procedures were in place for staff to follow in the event of the death of one of their patients. Any patient deaths were discussed in the monthly multi-disciplinary team meeting so that all staff including district nurses and palliative care teams were aware when a patient had died.

The practice maintained a list of patients receiving end of life care and this was available to the out of hours provider. The practice had close links with the palliative care nursing team and they attended the practice monthly multi-disciplinary team meetings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice offered annual health checks for patients over 75 years of age and there was the option for these checks to be carried out as home visits for patient unable to attend the practice due to illness or immobility. All patients over the age of 75 years had a named GP. The practice identified a list of patients over 75 years of age who frequently attended hospital or out of hours services and invited them for review to create personalised care plans. These patients were sent a health questionnaire that included questions on lifestyle and memory and this was reviewed with the patient when they attended their appointment or seen at home by the healthcare assistant. The practice provided medical care to all patients at a local nursing home and made weekly visits. They also provided medical care to elderly patients at two local residential homes when required.

The practice offered nurse-led annual reviews for patients with long term conditions. There was a system in place to alert practice staff when annual reviews were due and they sent out reminder letters to patients inviting them to attend for their review. Medication reviews were also undertaken with the support of the practice pharmacists to ensure that patient's medication needs were being met. Regular searches were performed to identify patients that required improvements to their long term conditions. For example, diabetic patient's records were regularly reviewed to identify if any screening was due or needed.

The practice had a named lead for safeguarding and there were alerts on patient's electronic records to make staff aware if there were any child protection plans in place. The practice offered childhood immunisations in line with national guidance and uptake rates were at or above the CCG average. There were as a policy to follow up on any patients who did not attend for the appointment. The practice offered nurse-led women's health clinics for cervical smears, family planning and sexual health advice. All women were encouraged to attend for regular cervical smear testing and the practice had a reminder system for patients who did not attend. A well-baby clinic and developmental check led by community health visitors was held at the practice weekly. There was advice on the practice website about starting a family and childhood immunisations.

The practice maintained a register of eight patients with learning disabilities and invited them for annual review of care plans. At the time of the inspection all but one of the annual reviews for these patients had been completed. One of the lead GPs had received training in managing patients with drug misuse problems and we were told the practice was pro-active in referring these patients to the local drug and alcohol team. Patients could be referred to see a community counsellor at the health centre the practice was based, for advice on alcohol and drug-related problems.

The practice had an experienced GP lead for dementia. Clinical staff told us they were pro-active in screening for dementia by using memory screening questionnaires in consultations and prompt referral to memory services if required. The practice maintained a register of patients with a diagnosis of dementia and invited these patients for annual health reviews. At the time of inspection 83% of annual health reviews had been completed. The practice kept a register of patients experiencing poor mental health and these patients were offered annual health reviews that included maintaining and updating individual care plans. The practice had completed 92% of these annual health and care plan reviews at the time of our visit. The practice had links with the community mental health team and could refer on to rapid community assessment teams if required. Patients experiencing depression or anxiety problems could be referred to see a community counsellor on site.

Tackling inequity and promoting equality

The practice had access to telephone translation services and patients were offered a double appointment if translation services were required. Some of the clinical staff spoke two languages and could assist in translation where appropriate. Default double appointments were also booked for patients where this was known would of

Good

Are services responsive to people's needs?

(for example, to feedback?)

benefit. Equality and diversity training delivered through e-learning had been completed by one member of staff and was due to be completed by the rest of the practice team by July 2015.

The practice was accessible to patients with disabilities and all treatment and consultation rooms were located on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open from 7.30 am to 6.30 pm on Mondays, Tuesdays and Fridays; 8.00am to 6.30 on Wednesdays; and 7.30am to 4.30pm on Thursdays. Appointments were available from 7.30am to 8.00am; 8.30am to 12.10pm and 3.00pm to 6.00pm on Mondays, Tuesdays and Fridays; 8.30am to 12.10pm and 3.00pm to 6.00pm on Wednesdays; 7.30am to 8.00am and 8.30am to 12.10pm on Thursdays.

Urgent same day appointments were available by contacting the reception. Telephone consultations were also available on the same day. Routine appointments could be booked three months in advance and there was the facility to book appointments online if patients had registered for this service. Home visits were available for patients unable to attend the practice due to illness of immobility.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. However, information on appointment times in the practice leaflet was not up to date compared to the practice 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 about the out of hours service was provided to patients.

Patients we spoke with were generally satisfied with the appointments system with many patients describing it as good and that it worked well. They confirmed that they could see a doctor on the same day if they needed to. This was reflected in the results from the national GP patient survey, for example 75% of respondents described their experience of making an appointment as good and 87% found it easy to get through to the surgery over the phone. These results were above the CCG average for the local area. The practice's extended opening hours from 7.30 am four times a week was particularly useful to patients with work commitments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy had been updated since our previous inspection on 1 September 2014 and the procedures were now in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice website. The practice information leaflet did not provide specific details on the complaints process and directed patients to speak with the reception team if they had an issue to raise. A separate complaints leaflet was available in reception.

We looked at five complaints received in the last 12 months and found they were dealt with in a timely way according to the practice complaints procedure. The practice reviewed complaints annually to detect themes or trends. Complaints were also discussed regularly in practice meetings to share learning and identify any action points.

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 mission statement to provide a better service for patients through empowering staff and encouraging patients to take joint responsibility for their health care with the practice. The practice leaflet and practice website included the practice's patient charter that set out the standards to achieve to provide the high quality care. These included the aim 'to treat patients with courtesy and respect, treat patients as partners in their care and provide full information on all services available'.

One of the GPs told us the practice's vision and mission statement were discussed at practice meetings to ensure all staff were aware and involved in reviewing them.

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. These included policies and procedures to cover health and safety, infection control and safeguarding. Most of the policies we reviewed were up to date and staff told us they were notified about any changes made to them.

There was a clear leadership structure with named members of staff in lead roles. For example, the GP partner was the lead for safeguarding and the practice nurse for infection control. Staff we spoke with were all clear about their own roles and responsibilities. They told us they felt 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 the practice showed it was achieving the minimum targets in the majority of areas. The practice had an on-going programme of clinical audits which were used to monitor quality and to identify where action should be taken.

The practice held monthly clinical and administration staff meetings where governance issues were discussed. We looked at minutes and confirmed governance issues were discussed and then disseminated to all staff.

Leadership, openness and transparency

We saw from minutes that team meetings were held 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 also noted that team away days were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy and qualification checking procedure, which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on fire safety procedures, repeat prescriptions policy and health and safety at work.

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

The practice had gathered feedback from patients through the patient participation group (PPG), national GP patient group survey and the Friends and Family Test (FFT). We looked at the results from the 2014 (FFT) and saw that 94% of respondents were likely to recommend the practice to friends and family if they needed similar care or treatment.

The practice had an active Patient Participation Group (PPG) that included representatives from various population groups including patients in full time employment and those who had retired. Members of the PPG were active in local community groups and worked with a voluntary group to support patients who were registered carers. Both the annual PPG report and two members of the group we spoke with highlighted difficulties recruiting new members and that was the focus for the coming year. They had identified areas were the practice population was under-represented, such as ethnic minorities and patients with young families and planned to focus on recruiting patients from these groups in the coming year. The PPG held regular meetings with the practice manager and produced a practice newsletter three times a year. The newsletter contained information on practice news and services available, for example promoting flu clinics and providing information on repeat prescription requests.

The PPG also conducted annual patient surveys. We were shown the results of the last survey for 2014 and 89% of patients questioned felt the practice was good, very good or excellent. The main concern highlighted from the survey was that not all patients were fully aware of the range of services offered by the practice and as a result the practice

Are services well-led?

Good

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

aimed to improve communication with patients. For example, some patients were not clear about the role of the nurse practitioner and in response the practice had updated their website and practice leaflet to include a section on her role and duties.

The practice had gathered feedback from staff through monthly practice meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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