Lea Vale Medical Practice

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lea Vale Medical Practice on 13 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students) and people experiencing poor mental health (including people with dementia) . It was outstanding for 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.
- Most patients said they found it easy to speak with or make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw two areas of outstanding practice:

- The practice sent nursing staff into a women's group and local schools used by the Polish community to

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provide advice about the importance of regular cervical smear tests as well as how to manage minor childhood illnesses. This had resulted in a decreased number of children being brought into the surgery with colds and other minor illnesses.

- The practice allowed homeless people to register the practice as their own address in order to support them to access other services and benefits.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they usually found it easy to speak with or make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet

Summary of findings

their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. 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 held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits, telephone reviews and rapid access appointments for those with enhanced needs. The practice also carried out weekly ward rounds at a local care home for elderly people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The senior partner was a specialist in managing long term conditions and nursing staff had lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that 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

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours including an asthma clinic during school holidays and the premises were suitable for children and babies. We saw good examples of joint working with other agencies including local schools.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had

Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. There was a specific vaccination programme offered to young people going away to university for the first time.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability and home visits to local care homes in which the residents had a learning disability. There was a lead nurse in the practice for patients with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Homeless people were able to use the practice as their registered address which enabled them to access other services and benefits. People using the local drug and alcohol rehabilitation service were welcomed as patients at the practice whether or not they lived in the area.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice had recognised that a significant number of its patient population were from Eastern European countries. In order to support those patients access the service Polish speaking reception staff were employed in the practice. Nursing staff regularly visited women's groups in the Polish community to promote regular cervical smear testing and also local infant schools to educate Polish parents on managing children's minor illnesses at home. In addition, an ongoing audit into the management of diabetes in Polish patients was underway at the practice as difference in how this condition was managed in Polish and British patients had been identified.

Summary of findings

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). 67% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice also offered its own counselling service into which patients could be referred; this had supported patients when there had been difficulties in getting timely referrals into community services.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. There was a lead nurse in the practice for patients with mental health needs (including dementia).

Summary of findings

What people who use the service say

We reviewed the results of the national patient survey and the annual survey carried out by the practice's Patient Participation Group (PPG). In the national survey 76% of patients described their experience of the practice as either good or very good. 885 patients participated in the PPG survey in which 67% of patients said they would recommend the practice to others.

We also spoke with four patients on the day of our inspection (the triage system meant that there were low numbers of patients attending the practice in person). Each told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One family told us the practice had been recommended to them by friends.

Outstanding practice

We saw two areas of outstanding practice:

- The practice sent nursing staff into a women's group and local schools used by the Polish community to provide advice about the importance of regular cervical smear tests as well as how to manage minor childhood illnesses. This had resulted in a decreased number of children being brought into the surgery with colds and other minor illnesses.
- The practice allowed homeless people to register the practice as their own address in order to support them to access other services and benefits.

Lea Vale Medical Practice

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, a CQC inspector and a CQC inspection manager.

Background to Lea Vale Medical Practice

Lea Vale Medical practice is situated in the Liverpool Road Health Centre in Luton. The practice has a patient list of approximately 22100, 69% of which are aged between 19 and 75 years and just 0.5% over 75 years. There are nine partners, including eight GPs and one nurse; two salaried GPs, a team of seven nurses and three healthcare assistants; a practice manager, an operations manager, a resources manager and a team of receptionists and administrative staff. There are five female and five male GPs. Staff work across three sites from which the practice is operates. The practice is a training practice and there are currently two GP trainees on placement there.

As part of this inspection we visited Lea Vale Medical Practice, 9 Mersey Place, Liverpool Road, Luton. The practice has two branch surgeries in the Farley Hill and Bushmead areas of Luton. We did not visit those surgeries as part of this inspection.

The contract held by the Lea Vale Medical Group for the services provided at Lea Vale Medical Practice is a PMS contract. PMS contracts offer practices 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 practice has opted out of providing an out of hours service to their patients. Patients are directed to NHS 111 when the practice is closed.

The practice had not previously been inspected. When the practice registered with the Care Quality Commission they told us they needed to make some improvements in relation to building and refurbishment needed in Liverpool Road Health Centre. The practice had submitted an action plan and during this inspection we checked the actions had been completed.

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 was 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:

- Is it safe?
- Is it effective?

Detailed findings

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England, the local clinical commissioning group and Healthwatch to share what they knew. We carried out an announced visit on 13 November 2014. During our visit we spoke with a range of staff including GPs, trainee GPs, nursing staff, the practice manager, reception staff 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 and reviewed the personal care or treatment records of patients. We reviewed comments on NHS Choices and in patient surveys where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, outcomes from checks, comments and complaints from the patients. There was a risk management policy in place which was updated regularly. Incidents, actions taken and the learning implemented were managed through the practice risk register. A responsible manager was identified for each incident investigation. We reviewed incidents which had occurred over the past twelve months and found that the practice could show evidence of a safe track record over that period of time. We saw that the practice had identified the transfer from one electronic records management system (EMIS) to another one (SystmOne) as a risk and mitigating actions including appropriate training for staff taken. This risk was reviewed regularly to ensure all appropriate actions had been taken in a timely manner.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff we spoke with were aware of how to report incidents including significant events. We saw evidence that reporting forms were completed and submitted by the member of staff identifying a risk or event and that this was then reviewed by the manager to whom the incident was allocated. Once incidents had been investigated the findings were discussed at clinical governance meetings and actions recorded. Learning from incidents was then cascaded via SystmOne to all relevant staff. Staff we spoke with were able to describe their learning from events.

National patient safety alerts were disseminated by alerts or email using the practice's electronic management system to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical governance meetings and learning then cascaded to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Nurses reported the actions they had taken in response to these alerts to the head nurse at the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. This was confirmed by members of medical, nursing and administrative staff who told us about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The population served by the practice included a significant number of people from Eastern Europe. Some receptionists spoke Polish and other East European languages and were able to support patients from those countries who required a chaperone.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Good

Are services safe?

Medicines management

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

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, prescription patterns of a hypnotic medicine used to help patients who have difficulty sleeping. The risks of reduction of prescribing this medicine in a particular patient group were discussed within the meeting demonstrating that the practice had carefully considered the impact upon those patients.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out annual audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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.

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

The practice was in a building which was owned by the local NHS trust. The Trust held responsibility for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). The practice held regular meetings with the Trust and was able to provide assurance that the Trust was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

The practice had not previously been inspected. When the practice registered with the Care Quality Commission they told us they needed to make some improvements declared non-compliance with Regulation 12, Cleanliness and infection control in relation to building and refurbishment

Good

Are services safe?

needed in Liverpool Road Health Centre. The practice had submitted an action plan and we checked the actions had been completed at this inspection. We were satisfied that the identified improvements had been carried out.

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 annually 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 the fridge thermometer.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. As part of the South Luton cluster of practices in the Luton CCG area Lea Vale Medical Practice operated a staff bank of administrative staff and nurses to ensure that annual and sick leave were covered. When GPs were absent the practice used locums from a local walk-in centre so they were familiar with the practice. When the locums were new to the practice they completed an induction before staring work.

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

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw evidence that risks were discussed at clinical governance meetings which were attended by both clinical and non-clinical staff. Each risk was given a severity rating and mitigating actions and learning discussed at the meetings then cascaded to staff as appropriate to the individual risks.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Reception staff and those working in the call centre to triage calls were able to identify where patients needed to be seen urgently by a doctor or nurse. For example, on the day of our inspection we observed that someone had been taken ill outside the practice and had received urgent attention from medical staff at the practice after being alerted by reception staff.

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. We observed that there was an emergency trolley accessible to all of the rooms in the corridor in which the consulting rooms were based.

The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and

Good

Are services safe?

hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

The practice had received assurance from the building's owners that a fire risk assessment had been carried out that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions and provide a greater number of appointments for patients with those conditions. A clinical tool was used to identify patients at risk of developing these conditions and they were then triaged to the specialist clinics. There was specific work carried out around diabetes in the Eastern European population of which there was a high number in the area served by Lea Vale Medical practice. Our review of the clinical meeting minutes confirmed that this issue and the work undertaken to improve the monitoring of blood sugars within that group was discussed in the meetings.

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

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 a system in place for completing clinical audit cycles. Examples of clinical audits included uncontrolled hypertension and the childhood immunisations. Both audits were carried out in 2013, the learning identified and then re-audited for impact on patient health approximately 12 months later.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

We saw evidence that the practice was routinely auditing its referrals into other services across a range of conditions, one example being gynaecological referrals. The practice's lead nurse described how this audit had identified that all referrals to secondary care for gynaecological conditions had been relevant and appropriate.

The management of long term conditions such as asthma and diabetes was also being reviewed for the effectiveness of the treatments prescribed over time.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

A rigorous system peer review of referrals was supported by the range of specialists GPs to ensure that patients' care pathways were appropriate and suited to their needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending the provider's mandatory courses such as annual basic life support. We noted a good skill mix among the GPs; all had specialist backgrounds which were utilised to ensure that patients diagnosed with specific conditions received care and treatment from a GP with specialist knowledge. All GPs were up to date with their yearly continuing professional

Good

Are services effective?

(for example, treatment is effective)

development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, one member of staff who had progressed from a volunteer post to a full time administrative post described a range of training they had received in order to become a receptionist and subsequently the practice research lead. They had attended regular courses and development meetings in their current role to ensure their knowledge was contemporary and relevant. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. Those with extended roles which were linked with the GP specialist roles in treating patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this. We were also told about an example of disciplinary action which had followed the practice's own policy and processes in full.

Working with colleagues and other services

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

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services 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 multidisciplinary team meetings regularly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice worked closely with the community health teams and the local hospital in order to provide an effective integrated care pathway for patients. The community midwife was based in the practice four days a week and would refer mothers and babies to the practice's immunisation clinics during appointments in order that opportunities to bring immunisations up to date could be optimised. A drug and alcohol rehabilitation service was close to the practice and referrals both to and from that service were encouraged by the practice.

For patients with mental health needs the practice worked with local services to ensure that those patients were referred for the most appropriate treatment. They described that referrals to secondary care for those patients had been difficult as those services were not always responsive. The practice offered its own services for patients with mental health needs such as talking therapies; counselling and other interventions within the NHS programme Improving Access to Psychological therapies (IAPT). A patient we spoke with told us that the counselling service had provided them with much needed support.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific situations where capacity to make decisions was an issue for a patient, the practice nurse who had specialist training in mental health assessed patients' ability to consent. This assured the practice that patients were supported to make their own decisions and the process documented in the medical notes.

Patients with a learning disability 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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

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

The practice had offered patients aged between 40 and 74 health checks and had been proactive in attempting to get those patients to attend by issuing each of them a personal invitation. At the time of our inspection 1450 patients had undergone the health check which represented 35% of the practice's eligible population. As a result of these checks some patients had been diagnosed with diabetes and hypertension and provided with treatment and advice to manage their conditions.

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. Those patients were offered an annual physical health check. The practice offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients with dementia, housebound and those receiving end of life care. These groups were offered further support in line with their needs. The practice maintained a register of patients who had caring responsibilities and may require further support to cope with those responsibilities.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. Walk in flu clinics were advertised on the practice website and flu vaccinations further promoted by a prominent display in the waiting room. Patients for whom contracting the flu virus presented a higher than average risk were identified and care plans set up to ensure they received the vaccination.

The practice's performance for cervical smear uptake was 80%, which was better than others in the CCG area. The practice had identified the need to educate some of the

Good

Are services effective?

(for example, treatment is effective)

Eastern European community in sexual health and common childhood illnesses. Nurses worked with women's groups to promote cervical smear testing. In response to high numbers of Polish parents bringing their children into the practice with minor illnesses, outreach work was carried out with local infant schools to educate those parents to manage those illnesses at home where possible. This had resulted in a decreased number of children being brought into the surgery with colds and other minor illnesses.

All practice nurses received training in health coaching from the practice nurse partner.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients had mixed views about the practice although they felt they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the worst' for patients who rated the practice as good or very good. However, the practice was similar to other practices for its satisfaction scores on consultations with doctors and nurses with 77% of practice respondents saying the GP was good at listening to them and 89% said nurses involved them in decisions about their care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received nine completed cards and the majority were positive about the service experienced. They said staff treated them with dignity and respect. We also spoke with four 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. We observed that patients were collected by the GP when their appointment was due and taken through to the consulting rooms which were accessed through a door fitted with a security lock. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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 national patient survey showed 77% of practice respondents said the GP involved them in care decisions.

Patients we spoke to 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. Some reception staff were native speakers of Polish and other Eastern European languages spoken by a significant number of the population served by the practice. We observed interactions between reception staff which were conducted in the patients' own language.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and the patient website told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice's nurse partner was the practice lead for patients with caring responsibilities.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a

Good

Are services caring?

patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Referrals to the practice's in-house counselling service were offered. Bereaved children from 3 – 18 years were referred to 'CHUMS', Bedfordshire's bereavement, trauma and emotional wellbeing support service for children.

There was helpful guidance on what to do following bereavement on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice was well represented within the CCG and we saw minutes of meetings where service improvements and educational work with the CCG had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, diabetes prevalence within the Eastern European population in the area covered by the practice was identified as needing to be addressed through better monitoring of patients' blood sugar levels and other health and lifestyle factors.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice's telephone service had been improved in order to ensure that call time waiting was reduced. In addition, the practice had introduced a text message alert service to remind patients of their appointment and offering them the opportunity to cancel appointments by responding to the text. This option had helped to reduce the number of patients failing to attend appointments (DNA) providing better access to appointments for others.

Tackling inequity and promoting equality

The practice was well aware of the ethnic mix of its patient population and how this had changed over the years, reflecting the population development in Luton Town Centre. There was a large stable population of patients of Asian heritage and a significant number of patients from Poland, particularly young working people with children. Several of the practice reception staff spoke Polish. A translation function was available on the practice website.

The practice had also done various pieces of work to address the different expectations of the Polish community in regarding to management of their health needs including gynaecological checks, diabetes and childhood illnesses. Advice on the importance of smear tests was on the website in both English and Polish. The practice was also aware of the growing number of patients from Romania who had recently come to live in Luton and told us that reception staff were able to communicate with those patients in their own language. We spoke with the parents of a young child in the reception area who told us that friends had recommended the practice to them both for the standard of care and the availability of Polish speaking staff.

We were told that the number of mother and baby clinics had been increased to meet the needs of the growing number of families, particularly in the Bushmead area of Luton in which the practice has a branch surgery.

GP services were provided by Lea Vale to care homes for older people and those with learning disabilities.

Homeless people in the area were registered at the practice and they could then use the practice as their address. Patients using the nearby drug and alcohol rehabilitation centre were also often referred to the practice and the practice worked closely with the service to ensure that those patients received the appropriate care pathways to meet their individual needs.

There was a lead nurse for patients with mental health issues (including dementia) and learning disabilities. They told us how they worked with other organisations including the local authority and charities to support those patients. We noted that the nurse was aware of how more vulnerable patients such as those who were homeless or had recently moved to England were susceptible to mental health problems due to their individual circumstances. These patients were monitored for signs of anxiety and signposted or referred to appropriate mental health services.

Access to the service

Appointments were available from 07.30am – 7.00pm at the Liverpool Road surgery whilst both branch surgeries were open 8.30 – 18.00. Baby clinics and smear clinics could be accessed during the extended opening hours. Calls for appointments were triaged by the practice call centre as the practice had recently begun using the Doctor First appointment system in order to reduce waiting for appointments and patients failing to attend pre-booked appointments (DNA). Children and patients with long term

Good

Are services responsive to people's needs?

(for example, to feedback?)

conditions, those for whom English was not their first language and any presenting worrying symptoms were prioritised for urgent appointments. Following the triage arrangements were made for GPs to call patients back if an urgent appointment was not needed. Patients were able to call all day and would receive a call back from one of the most experienced GPs. Both the practice manager and patients we spoke with told us that this had been a success and waiting times for appointments had been reduced. This change was made through work the practice had done with the practice's Patient Participation Group (PPG). Waiting times had been further improved as the practice used its computerised system to send patients text and email reminders regarding their appointments. There was also the facility for patients to cancel their appointments by replying to the reminders which over the course of a month had halved the number of patients not attending their appointments.

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. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on how to contact the out-of-hours service via111 was provided to patients. Guidance was also given on when patients should call 999 rather than contact the out of hours service. Online prescription ordering was also available on the website.

Longer appointments were also 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 a local care home on a specific day each week, by a named GP and to those patients who needed one. Older patients with mobility problems were offered reviews by telephone where appropriate.

Patients were generally 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. There were both male and female GPs in the practice. The GPs were supported by a large nursing team. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, we spoke with parents who were attending their first appointment with their young child. They told us that the practice had given them an urgent appointment when they called that day. They had recently registered with the practice and told us that they completed a thorough assessment of their health history at registration. Another patient we spoke with had been referred by their GP at another practice to the practice's counselling service. They told us they were very happy with that service and they had only had to wait two weeks for their first appointment.

Listening and learning from concerns and complaints

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

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

We looked at complaints received in the last 12 months and found these to have been handled in a timely way. The complainants had received written responses detailing how their complaints had been investigated and the outcome of the investigation.

The practice held a register of complaints which enabled them to detect themes or trends. We looked at the summary for the last twelve months and no themes had been identified. However, lessons learned from individual complaints had been acted on. We reviewed minutes of the practice's clinical governance meetings and noted that learning from individual complaints was discussed there. A cross section of staff groups were represented at these meetings which ensured that the learning was appropriately cascaded.

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 strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included the promotion of equality of access to health care for the practice's registered population and the development and integration of care across the whole of the primary care team. In addition the use of clinical teaching, audit and research were identified as the ways in which to foster an innovative approach to the development of care.

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. A trainee GP and the practice research lead were included within the staff group with whom we spoke. Both confirmed their own experiences of how the practice vision was applied to their learning and development within the practice team.

We were told that the practice had a commitment to register anyone who wished to register with them as a patient. There were strong links with local charities including those for homeless people and a drug and alcohol rehabilitation centre. In addition the practice had carried out work in local schools and Polish women's community groups to promote understanding of the services they offered as well as self-management of minor illnesses.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at four of these policies and procedures and found they had been reviewed annually and were up to date. Staff we spoke with were aware of the policies and their content.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for long term conditions. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. We noted that clear succession planning had been considered and implemented as a result of the senior partner wishing to reduce their hours as they approached retirement age. As the partner's specialism was in long term conditions the partners' meeting had discussed this and agreed that recruitment of a new partner with that specialism should be immediately undertaken as finding someone with the right background could be a lengthy process.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. QOF is a national performance measurement tool.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the prescribing of opiates for non-cancer patients. Recent guidance had warned that these should not be prescribed for patients who did not have cancer or another terminal condition. The practice had identified that a large population of substance misusers and other patients were inclined to opiate consumption and the purpose of this ongoing audit was to reduce the prescription of opiates to those patients. Other ongoing audits included the number of referrals of patients with gynaecological conditions to hospital and the care of children with suspected urinary tract infections.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as a power failure during out of hours and the actions required to ensure the continued validity of vaccines stored in the fridge. The manufacturer had been contacted to confirm the maximum temperature at which the vaccines could be stored and the landlord asked to provide a back-up generator. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example where the identity of twins had been confused at the booking in for an appointment. Staff had been instructed to request photo identification in such situations in the future.

The practice held monthly clinical governance meetings. We looked at minutes from the last three meetings and

Are services well-led?

Good

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

found that performance, quality and risks had been discussed. There were also partners meetings and an executive team meeting which had delegated decision-making powers. The membership of this executive board included the practice manager and four partners. Decisions taken by the executive team were subject to ratification by the partnership board.

Leadership, openness and transparency

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 also noted that protected learning time sessions were held monthly on a Wednesday afternoon. Staff told us that guest speakers frequently attended these sessions and those developments in the practice such as research projects were shared and discussed at those sessions.

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

Lea Vale Medical Practice worked with six other practices within the South Luton cluster of Luton CCG. A number of initiatives had been implemented including across cluster review of referrals and referral pathways.

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

The practice had gathered feedback from patients through patient surveys and complaints. We looked at the results of the annual patient survey and 59% of patients had used the telephone service which had been introduced since the last survey. We reviewed a report on comments from patients during the year ending 31 March 2014, which had a common theme of patients not understanding the new appointments system. The report stated that progress against the resulting action plan had been made in that the website had been significantly updated and quarterly newsletters produced.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG included representatives from various population groups. The PPG had carried out quarterly 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. The results and actions agreed from these surveys were available on the practice website. The chair of the PPG told us that there was always a member of the PPG on interview panels when GPs and nurses were recruited.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around chaperoning at the staff away day and this had happened. 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.

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 four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice. At the time of our inspection there were two GP trainees on placement there. We spoke with one of the trainees who confirmed that they were well supported in their training by all staff at the practice. The practice manager told us that two previous trainees had been recruited to the practice and were still in post. At the time of our inspection the practice was in the process of gaining accreditation to provide placements for student nurses.

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

Are services well-led?

Good

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

patients. For example, following a breach of security staff were instructed to ensure only patients with appointments were able to go through the door and to safely challenge people who they did not believe were patients.