Belsize Priory Medical Practice - Group

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?	Requires improvement
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 Belsize Priory Medical Group Practice on 1 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, caring and responsive services. The practice required improvement for providing an effective service. It was also good for providing services for the provision of care to older people, those with long term conditions, working age (including those recently retires and students, those whose circumstances make them vulnerable and those experiencing poor mental health (including those with dementia). It required improvement for providing a service to families, children and young people.

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, with the exception of those relating to recruitment checks.
- 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.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments.
- The practice had an active patient participation group (PPG).

The areas where the provider must make improvements are:

- Ensure disclosure and barring service (DBS) checks are undertaken for all staff undertaking chaperone duties;
- Ensure a programme where clinical audits are carried out periodically and improvements shown.

In addition the provider should:

- Ensure meetings are documented more fully showing actions taken;

Summary of findings

- Ensure that significant events and incidents are discussed and learning disseminated through the practice.
- Produce a practice risk register to log both clinical and non-clinical risks to the practice and the patient population.

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 their responsibilities to raise concerns and to report incidents and near misses. The practice undertook a thorough investigation of each event. However there was no documentation to show lessons learned were communicated to the wider staff team to support improvement. Risks to patients were assessed and well managed. We found that non-clinical staff acting as chaperones had not received a disclosure and barring service (DBS) check.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services as there are areas where it should make improvements. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. However there was no evidence that NICE guidance was formally discussed in practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff received training appropriate to their roles. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams on a regular basis. The practice had undertaken some clinical audits but there was no evidence of a completed audit cycle.

Are services caring?

Good

The practice is rated as good for providing a caring service. The national patient survey 2014 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 was accessible and easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services for patients. Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were available the same day. Patients could get information about how to complain. Complaints that had been finalised were discussed within practice meetings.

Summary of findings

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. There were some systems in place to monitor and improve quality and identify risk. However the practice did not have a formalised process to monitor risk which caused a potential risk of missing. The practice proactively sought feedback from staff and patients, which it acted upon. The patient participation group (PPG) was active. Staff had received inductions, regular appraisals and attended staff meetings.

Summary of findings

What people who use the service say

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

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

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

We viewed the national GP patient survey for 2014 and found that 56% of patients that completed the survey found the overall experience good. The practice scored particularly well in being able to speak to their preferred GP (62%), which was higher than the Clinical Commissioning Group (CCG) average of 50%, and GPs being good at listening (87%) which was also higher than the CCG average of 85%. Areas which the practice had poorer scores included getting through to the practice by telephone (50%) compared to the CCG average of 73%. In the latest patient survey carried out by the practice's Patient Participation Group (PPG), 67% of patients who completed the survey rated the overall service provided by the practice as either excellent or very good.

The main concern that was raised by patients was access to the practice by telephone. The practice addressed this issue by deploying more staff to telephone duties at peak times and increasing telephone consultations.

Areas for improvement

Action the service MUST take to improve

- Ensure disclosure and barring service (DBS) checks are undertaken for all staff undertaking chaperone duties;
- Ensure a programme where clinical audits are carried out periodically and improvements shown.

Action the service SHOULD take to improve

- Ensure meetings are documented more fully showing actions taken;
- Ensure that significant events and incidents are discussed and learning disseminated through the practice.
- Produce a practice risk register to log both clinical and non-clinical risks to the practice and the patient population.

Belsize Priory Medical Practice - Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. It included a GP advisor who was granted the same authority to enter the Belsize Priory Medical Group Practice as the Care Quality Commission (CQC) inspector.

Background to Belsize Priory Medical Practice - Group

Belsize Priory Medical Group Practice is a surgery located in the London Borough of Camden. The practice is part of the NHS Camden Clinical Commissioning Group (CCG) which is made up of 40 practices. It currently holds a GMS contract and provides NHS services to 4296 patients. The practice serves a diverse population with many patients attending where English is not their first language. The practice does not have a large older population (5%) with 19% of the population under the age of 14. The practice is situated within a health centre shared with other primary medical services including midwives and physiotherapists. Consulting rooms are available on the ground floor for those with a physical disability. There are currently three GP's (1 male and 2 Female), however one GP is currently on long term leave, one practice nurse, a healthcare assistant, a number of administrative staff and a practice manager. Appointments are available between 7.15am to 1.30pm and then 2pm to 6.30pm on a Monday, Tuesday and Friday.

The practice is open for appointments until 7pm on a Thursday and closed on a Wednesday afternoon for staff training. Telephone consultations and home visits are also available for those patients unable to come to the practice.

The practice opted out of providing an out of hours service and refers patients to the local out-of-hours provider or the '111' service.

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

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice provides a range of services including child health and immunisation, minor illness clinic, smoking cessation clinics and clinics for patients with long term conditions. The practice also provides health advice and blood pressure monitoring.

Detailed findings

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 1 December 2014, as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations including Camden Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 1 December 2014. During our visit we spoke with a range of staff including GPs, practice nurse, practice manager and administration staff. We spoke with patients who used the service including representatives of the Patient Participation Group (PPG). We reviewed 4 completed Care Quality Commission (CQC) comments cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used information and systems to identify risk and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and how to report incidents.

We reviewed safety records, incident reports and minutes of team meetings for the past 12 months. This showed the practice had managed these consistently over the period; however there was a lack of documented evidence to show that incidents were discussed within team meetings.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. There were records of significant events that had occurred in the last 12 months and we were able to review these. Significant events forms were completed for each occurrence and actions recorded which included learning outcomes and meetings with relevant parties involved. However we reviewed staff meeting minutes and found that no follow up discussion was recorded and no record of learning being disseminated throughout the practice existed.

Staff used significant event review forms and an incident book placed in the reception area to record all incidents and significant events that occurred within the practice. These forms were given to the practice manager. We were shown the system used to manage and monitor incidents. 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 the manager of a nursing home telephoned the surgery and requested a visit from the duty doctor. The duty doctor failed to pick up the call and the resident of the warden controlled accommodation was subsequently admitted to hospital. It was found that there was a breakdown in communication within the multidisciplinary team. The practice held a meeting to emphasise the need for more communication between the doctors and the district nurse and ensuring that all parties had the practice by pass telephone number for use in an emergency. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology.

We found that safety alerts received from the NHS central alert system were disseminated to the appropriate staff and acted upon. For example a recent Ebola alert was sent to relevant clinical staff and discussed in team meetings so all staff were aware of the procedure to follow if a patient was suspected of carrying the virus.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Practice training records that were made available to us showed that all staff had received relevant role specific training on safeguarding of adults and children. We asked members of clinical 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 aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible within the administrative office and reception.

The practice had a dedicated lead GP appointed as lead in safeguarding vulnerable adults and children. All clinical staff had been trained in child protection to Level 3 and non-clinical staff to Level 1. All staff we spoke to were aware who the lead was and who to speak to if they had a safeguarding concern within the practice.

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

A chaperone policy was in place and visible in the consulting rooms and staff had undertaken relevant training. Both clinical and non-clinical staff undertook chaperone duties. Disclosure and barring service (DBS) checks had only been carried out for clinical members of staff and no risk assessment had been carried out by the practice to determine the reason for not providing a DBS check for all staff. Therefore some non-clinical staff that carried out chaperone duties did not have a DBS check.

Good

Are services safe?

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

Medicines management

The practice had a dedicated member of staff appointed as lead in medicines management. We checked medicines stored in treatment rooms, medicines store room and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was on display in the medicines store room. We found that vaccines were stored within the correct temperature range and temperatures were checked daily.

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

Vaccines were administered by the nurse using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example how staff generate prescriptions, how changes in a prescription was managed and when prescriptions were to be reviewed. This helped to ensure that patients repeat prescriptions were still appropriate and necessary.

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 practice to be clean and tidy. Responsibility for the cleaning was taken by the buildings management company. The practice had processes in place to ensure that cleaning was carried out and maintained to an appropriate level. We were provided with a copy of the cleaning schedule used by the company which the practice used to check that cleaning has been undertaken. Any issues with the cleaning were reported to the building management to be rectified.

The practice had a practice nurse lead for infection control. All staff received infection control training specific to their role. We saw evidence that the practice had carried out annual audits of infection control and monthly monitoring of the cleaning standards. Improvements identified for action had been completed on time. For example the annual audit had identified that there was no cleaning schedule for medical equipment such as blood pressure cuffs and peak flow meters. This shortfall had been rectified and we saw evidence of these schedules in use.

An infection control policy and supporting procedures was available of staff to refer to, which enabled them to plan and implement control of infection measures. For example a policy was available for the safe handling and processing of samples.

Hand hygiene technique signage was displayed in all toilets and within consulting rooms. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available.

The practice had undertaken risk assessments and testing for legionella (a germ found in the environment which can contaminate water systems in buildings) to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us that they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us equipment was tested and maintained regularly and we saw equipment maintenance logs that confirmed this. All portable electrical equipment had recently been tested by the building management and displayed stickers indicating the last testing date. The building management held a schedule of testing and the practice were awaiting their copy. We saw evidence of calibration of relevant equipment; for example weighing scales, fridge thermometers, nebulisers, spirometers, blood pressure monitors and vaccine fridges.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

Good

Are services safe?

references, qualifications and registration with the appropriate. Only clinical staff had received a disclosure and barring service (DBS) check. 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 needed to meet patients' needs. We saw there was a rota system in place to ensure there was enough staff on duty. There was an arrangement in place for staff to cover each other's annual leave.

Staff told us that there was an issue with GP continuity as there had been a locum GP for 12 months and another on maternity leave and felt there was a need for more nurse cover. The practice nurse worked for 1 ½ days per week and the two healthcare assistants work for two days a week.

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 a health and safety risk assessment of the practice. The practice had a health and safety policy. Health and safety information was displayed throughout the practice. The practice did not hold a risk register to determine and manage current risk to the practice. However we did see that risk was discussed within practice meetings. For example the correct procedure for undertaking a fire drill was discussed and actions from the health and safety risk assessment was shared with staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Training was refreshed annually. Emergency equipment was available including oxygen and defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records showed that these were checked regularly.

Emergency medicines were available within the medicines store. These were held securely and staff knew of their location. These included those for treatment of cardiac arrest and anaphylaxis. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A disaster handling and business continuity plan was in place to deal with a range of emergencies on the daily operations of the practice. Risks identified in the plan included loss of telephone system, loss of access to computerised medical records, loss of power, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Requires improvement

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. However we found no evidence of where new guidelines were discussed in practice meetings and disseminated or where the implications for the practice's performance was discussed. 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 where appropriate.

The GPs told us they lead in specialist areas such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD) and the practice nurse supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

To ensure that patients who may be at a higher risk and needed a more detailed needs assessment were identified, the practice identified the top 2% of a particular group, for example patients with a high attendance at accident and emergency (including older patients), long term conditions and those patients with mental health concerns. Best practice guidance would then be used to discuss these issues with patients and provide the most up to date care. All unplanned admissions to hospital were reviewed in clinical meetings; however there were no minutes of clinical meetings available to confirm this. We viewed 6 care plans for patients identified by the practice and saw how a plan was put in place with the practice to effectively manage their health concerns which included regular reviews. Patients were referred to local services including the community mental health team for further testing and diagnosis.

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 COPD and those patients with a suspected cancer.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GPs and practice manager showed that the culture in the practice was that patients were referred on need, and that no other factors, such as age, sex and race were taken into account in the decision making process.

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, medicines management and managing child protection alerts. The information collected was collated and used to assess the performance of the practice.

The practice showed us 2 clinical audits that had been undertaken within 2014. For example, an audit was undertaken of patients with an upper and lower gastrointestinal (GI) cancer diagnosis. The audit showed that patients were seen within the two weeks following the referral and that patients with further chronic conditions were routinely monitored. However the practice found that there were areas for improvement which included recording a more thorough medical history. However we were not given any other evidence of clinical audits to demonstrate an audit cycle.

We found evidence that staff attended local meetings to discuss accident and emergency attendance, emergency referrals and referral pathways for elective referrals.

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local Clinical Commissioning Group (CCG) as a whole against the national average. The latest available QOF data showed that overall the practice is performing above the CCG average (91.3%) and the national average (93.5%) achieving 97.7%. This was a general figure which included all areas that QOF covered (clinical care, how well the practice was organised, patient viewed, amount of extra services offered by the practice). The practice used this information to ensure that they were on target to deliver a good service and to discuss, in both clinical and practice meetings, how service could be improved.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions

Requires improvement

Are services effective?

(for example, treatment is effective)

such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that GPs recorded in patient notes the rational for prescribing a particular medicine. This showed that the GP had oversight and a good understanding of the best treatment for each patients' needs.

The practice held a palliative care register and had regular meetings with the palliative care specialist nurse 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. The practice was benchmarked against nine other local services and it was found that they were only one of three services performing above the benchmark for the management of long term conditions.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all have 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 the NHS England can the GP continue to practice and remain on the performers list with the General Medical Council) The practice acknowledged that there is currently an issue with the mix of staff with more clinical and administrative staff needed to fulfil patient demand for services. The practice was currently recruiting for more staff to undertake these roles.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff confirmed that the practice provided training and funding for relevant courses. For example customer service training.

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

Working with colleagues and other services

The practice worked well with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy for reading and acting on any notifications received. The GP who saw the document and results was responsible for the action required. All staff we spoke with understood their roles.

The practice was commissioned for a range of enhanced services which included dementia care, avoiding unplanned admissions, complex care, drug misuse and smoking cessation. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). However there was no evidence of annual audits of these services being carried out.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those in end of life care and those with a learning disability. Meetings were attended by district nurses, social workers, palliative care nurses, community midwives and health visitors. These meetings were documented in meeting minutes and within the patients shared care record. The GP Lead had an arrangement with the community mental health team to review shared care records on a quarterly basis. The practice undertook joint home visits with the community mental health team, community matrons and the community elderly care consultant to provide a service to the vulnerable and frail elderly. The practice also undertook joint reviews and visits with the community substance misuse team.

Information sharing

The practice used the electronic Choose and Book system for making referrals. The system enabled patients to choose which hospital they wished to be treated in and book their own outpatients appointment in discussion with their chosen hospital. The practice also used a shared system to share information with other health providers including the local out of hour's provider.

The practice had systems in place to provide staff with the information that they needed. This included an electronic patient record card which was used by all staff to coordinate and document treatment. The electronic card

Requires improvement

Are services effective?

(for example, treatment is effective)

contained a complete medical history for the patient which was used as both a reference for the treating professional and also a tool to update current treatment. The software enabled all paper communications such as hospital letters to be scanned onto the electronic card. All staff had received full training in the system.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children's Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and was able to describe how they implemented it in their practice. For example when making Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for patients receiving end of life care.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have legal capacity to consent to medical examination and treatment). We were provided with the practice policy for determining the capacity of patients under 16 to give consent and the procedure for the practice to follow. The practice also had a policy for ensuring that patients with a learning disability were able to provide appropriate consent to treatment.

Health promotion and prevention

All new patients were offered a consultation with the practice nurse to discuss the patient's lifestyle and to provide information to help improve their lifestyle. This included healthy eating and exercise leaflets and smoking cessation advice. Chlamydia testing and advice was also offered as part of the initial patient consultation for those patients within the age range for this testing. Sexual health advice was offered to patients who were signposted to other health organisations if an issue was identified. The practice also offered a full children's immunisation programme. Immunisation rates were mixed compared to the Clinical Commissioning Group (CCG) rate. For example, in 2013, the practice vaccinated 63.4% for the MMR and the CCG average was 83.2%. However the practice vaccinated 94.4% against infant Meningitis c compared to the CQC average of 90.8%. The practice telephoned patients who did not attend for vaccinations.

The practice shared the care of mothers and children with the community midwives team and the practice nurse to provide antenatal care and support to new parents, including support for the families of premature babies. The practice also operated a register of children at risk or in social services care and GP's attended joint meetings to discuss care. The GP also provided a report for the transition of young people in social services care to adult services.

The practice offered annual health checks and advice to all patients on the practice list with specific checks for those placed on the long term conditions register which included structured annual reviews, diabetes checks and blood pressure monitoring. Chronic obstructive pulmonary disease (COPD) checks were also carried out and included spirometry checks (measuring lung function). The practice had undertaken annual reviews for 65% of patients on the practice long term condition registers. The reviews included a medicines check to ensure medicines were still relevant to the condition. Smoking status was added to patient records and smoking cessation classes were run on an ad hoc basis. The practice was unable to provide data regarding quit rates but advised that 76% of patients recorded as smokers were currently receiving support from the practice. Of those patients registered as smokers, 98% had received chronic disease advice. The practice proactively monitored patients who may develop a long term illness through the practice computer system. These patients were called in on an annual basis for a health check to monitor any developments.

The practice had 88 patients on the mental health register and all had an agreed care plan. The practice provided annual physical health checks to patients on the register along with regular mental health reviews. However only 41% of patients on the register had received a depression review. Each patient on the older persons register received a named GP contact. The practice also attended meetings with the local mental health teams to discuss the case management of patients on the mental health register where the GP's provided regular health reports for the meetings.

The practice had a 68% uptake for cervical screening. The practice was aware of this matter and were promoting this service within the practice and sending reminders to those patients that were due to be screened.

Support was given to working people who became ill through medical certificates and the fit note. However the practice did not audit these certificates. We found evidence

Requires improvement

Are services effective?

(for example, treatment is effective)

that 79% of working age patients had received a blood pressure check in the last 12 months. Extended hours appointments were available for those people that could not attend during working hours.

Health advice leaflets were available within the reception area or direct from the nurse. However leaflets were only available in English.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and the practice initiated patient improving practice questionnaire (PIPQ). The evidence from these sources showed us that patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey 2014 showed that 87% of respondents said that the last GP they saw or spoke to was good at listening to them, which was above the Clinical Commissioning Group (CCG) average of 85%. The PIPQ carried out in 2014 showed that 73% of patients were happy with the GP's ability to listen to them. This was below the national mean score of 82% which was used to benchmark the results.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and all were positive about the service. Patients said they felt the practice offered an excellent service and that staff were always obliging. We also spoke with nine patients on the day. All told us that they were happy with the care provided by the practice.

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 so that patients' privacy and dignity was maintained during examinations. We noted that consulting 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 within the reception area that was shielded by a glass partition. Seating was located some distance from the reception desk which enabled privacy at the reception desk.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour they would raise these with the practice manager. The practice manager told us she would investigate these and any learning shared within practice meetings.

Care planning and involvement in decisions about care and treatment

The results of the national patient survey 2014 showed that the practice scored above the CCG average of 65% for GP's explaining test results gaining 68%. However the practice scored 68% in the same area for the patient improving practice questionnaire (PIPQ) which was below the national mean score of 81%. During our inspection patients said the GPs and nurses involved them in decisions about their care and treatments and this was reflected in the CQC comment cards received.

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

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

Patient/carer support to cope emotionally with care and treatment

The survey information we viewed showed that people were positive about the emotional support that was provided by the practice. People told us that when they needed emotional support the GP would go out of their way to offer support through providing an appropriate referral to another service or by providing information of how they could access relevant support groups. We viewed information within the reception area for groups that offered external support.

The practice had a carer's policy and the practice computer system alerted GPs if a patient was also a carer. We were shown written information signposting carers to support groups. Patients who suffered bereavement were telephoned by the GP and invited to the practice to discuss how staff could be of any help.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs. The needs of the local population were understood and services were in place to meet them. For example extended hours were available for patients that could not attend during working hours. Longer appointments were available for those who had complex care needs. Special services were delivered for those with substance misuse issues. The practice also liaised with the Clinical Commissioning Group (CCG) to secure services for patients.

The practice had a policy to deliver all services available related to the identified needs of its patient population. The practice proactively sought feedback through a patient meeting where patients were asked what services were needed. This was an open meeting held by the practice to find the views of the wider patient population and was separate from the patient participation group (PPG) activities. The practice identified a need for the establishment of dementia care, diabetic clinic and smoking cessation. Staff assessed the needs using the practice registers, contacted patients and organised special service slots within the week to deliver care. For example a special diabetic clinic was established. This service was monitored and assessed to ensure patient demand and the correct amount of time was allocated.

Patients we spoke with said sometimes it was difficult to see the GP of their choice which was hindered by one GP currently absent from the practice. The practice was currently recruiting to reduce this issue and provide more continuity.

The practice has implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). For example patients commented that they waited a long time for the telephone to be answered. The practice ensured an extra receptionist was available in the morning to cope with the extra demand. Patients also commented that it was difficult to get blood test results quickly. Therefore the practice opened a telephone line each day for one hour for patients to receive results. The practice also ensured that a duty doctor was available in that time to discuss any results over the telephone with patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. For example for those patients with "no fixed abode", temporary registration with the practice was offered and patients were not required to provide proof of address in order to be able to register with the practice. The practice had a large proportion of substance abuse patients and the practice ensured that they had access to the community substance abuse team.

The practice had access to online translation and a telephone translation system which could be booked for consultations.

The premises was fit for use by those people with a physical disability and those patients with push chairs. The practice had a wide layout where wheelchairs could turn with ease. All consultation rooms were on the ground level with wide corridors that provided easy wheelchair access.

The practice actively supported people who had been on long term sick leave to return to work by the use of the 'fit note' and a phased return to work.

Access to the service

Patients we spoke with said they could generally get an appointment at a time that suited them with a GP but this was not always the GP of their choice. This was reflected in the national patient survey where the practice scored in line with the Clinical Commissioning Group (CCG) average.

Appointments were available between 7.15am to 1.30pm and then 2pm to 6.30pm on a Monday, Tuesday and Friday. The practice was open for appointments until 7pm on a Thursday and closed on a Wednesday afternoon for staff training. Appointments could be made in person, by telephone or online. Urgent appointments were available on the same day with emergency slots reserved at the end of a session. Appointments were usually 10 minutes in length but extended appointments were available. The practice determined the length of the appointment through the number of issues to be discussed by the patient and the type of appointment needed. Telephone consultations and home visits were also available for those patients unable to come to the practice.

The practices extended hours on were particularly useful to patients with work commitments. This was confirmed by patients stating that they were happy that they could make an appointment to see their GP either before going to work or at the end of the day which gave the flexibility to see the

Good

Are services responsive to people's needs?

(for example, to feedback?)

GP around their working hours. The practice had recently installed an electronic prescription service which meant that patients could request a repeat prescription online, which was authorised by the GP and sent to the pharmacy for collection.

Patients we spoke with were generally satisfied with the appointments system however concerns were raised through patient feedback gained on the day of the visit, of the inability to get through to the practice on the telephone. The practice responded to this by ensuring more staff were available to answer telephone calls at peak times.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hour's service.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We saw that information was available to help patients understand the complaints procedure, which included a complaints leaflet and posters on display in the waiting area. 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 needed to make a complaint about the practice.

We looked at eleven complaints received in the last 12 months and found most of these were handled appropriately in line with the practice policy. However we could not find evidence that some complaints had been resolved.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and a common trend of complaints of poor communication on the part of one of the GPs. We saw evidence where complaints had been discussed in practice meetings to provide learning for the staff team.

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 long term strategy which included increasing the list size, the employment of more GPs and the move to a new premises.

We spoke with seven members of staff and they knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All six policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding and mental health management. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued and supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. However we found no evidence that QOF data was discussed at practice meetings and improvements considered.

The practice undertook some clinical audits but there was no evidence of audits being linked to reviews of any significant events or clinical alerts sent via the NHS central system. There was no evidence of any audit cycle being in place or of completed audit cycles.

The practice had arrangements for identifying, recording and managing risks. This included health and safety risk assessments and medicines management. The practice did not hold a log of current risks to the practice.

We were informed that the practice held monthly governance meetings. However minutes for these meetings were not available.

Leadership, openness and transparency

We saw from minutes that team meetings were held on a monthly basis. However not all meetings were well documented and there was no mention of discussion of learning points from any significant events. Staff told us that there was an open culture within the practice and had the opportunity to raise issues.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction policy, disciplinary procedures and whistleblowing procedures. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through a comments box, complaints, through the practice website and the annual satisfaction survey. We looked at the results of the annual patient satisfaction survey and 62% said that telephone access was good. However the practice sought to improve this by deploying more staff to answer the telephone at peak times and increasing the time allocated to make appointments. The survey also showed that 71% had confidence in the ability of the staff.

The practice had an active patient's participation group (PPG) which was representative of the patient population. The PPG organised an annual survey. The results from the most recent survey showed that issues were identified in regard to telephone access, appointments not being long enough for complex issues and patients wanting to be seen within 48 hours. The practice responded by increasing the opening hours of the telephone lines, providing the opportunity to book double appointments and determining the length of the appointment on the number of health concerns to be discussed, and increasing the number of emergency appointments for each session.

Staff told us that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. However some members of staff said that they were hesitant to say what they feel as they felt that the management would not listen to them. One member of staff told us that they asked for further training around the electronic filing system and this had happened.

Are services well-led?

Good

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

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 seven 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 if training needs were identified, these would be facilitated through training courses or through online training.