The Practice Northumberland Avenue & Luker Road

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 'The Practice Surgeries Limited', Northumberland Avenue, Southend, on 05 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive, and well-led, 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), people whose circumstances may make them vulnerable, and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, 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.
- The practice regularly reviewed their appointment system to meet the needs of their growing practice population.

We saw one area of outstanding practice:

Summary of findings

- Weekend surgeries, with regular clinical staff, were used to provide clinics for monitoring patients with long term conditions as well as for regular appointments.

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 through meetings to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and the practice responded appropriately. The staffing levels were appropriately managed and maintained to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) which had been made easily accessible on the computer system and was used routinely. People's 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 planned as part of the appraisal system. The practice had appraisals and the personal development plans in place for all staff. Staff worked with multidisciplinary teams to ensure proactive care pathways.

Are services caring?

Good

The practice is rated as good for providing caring services. 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 clearly written and available at the practice on the notice boards in the practice leaflet and on the website. 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. Since the practice was set up in 2008 they had established exceptional information and support services with the collaboration of local healthcare professionals to ensure they could provide patients with the services they needed. The practice had an excellent understanding of their population demographics and their specific health and social needs. We found the practice had introduced positive service improvements for their patients that were over and above their contractual requirements. This included opening on

Summary of findings

Saturday and Sunday to provide services seven days a week. The practice reviewed the needs of their local population and engaged with social care agencies and relevant health care professionals to deliver multidisciplinary care and support to their patients.

The practice reviewed the needs of its local population and engaged with their own patient group, the NHS Area Team and Clinical Commissioning Group (CCG) to ensure improvements to services where these were identified. Patients said they knew how to make an appointment with a named GP and that there was continuity of care. Urgent appointments were available the same day. Patients also told us both on the day and on the comment cards we received how much they appreciated the surgery opening seven days a week.

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

Information about how to complain was available and clearly written and evidence showed that the practice responded quickly and appropriately to issues raised. Learning from complaints with staff and other stakeholders took place during meetings and was evidenced in the minutes we reviewed and the monthly reports we saw that were sent to the provider that owned the practice.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff knew the practice values and their responsibilities in relation to them. There was a clear leadership structure and staff felt supported by management. The practice had a number of provider led policies and procedures to govern activity, and sent regular reports to the provider to ensure governance for the practice were reviewed. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients, and acted upon it. The patient participation group (PPG) worked with the practice manager and staff to look after patient interests. Staff had received inductions, regular performance reviews and attended staff meetings and training events.

Summary of findings

What people who use the service say

During our inspection we spoke with six patients who gave us positive comments about the care and treatment they received at the practice. Two patients told us they preferred the opening hours at this practice as opposed to the previous practice where they were registered.

The patients we spoke with on the day of our inspection told us they were more than happy with the care provided by the practice, and said their dignity and privacy was respected. Each patient we spoke with was keen to express to us why they thought the practice was good at responding to their particular needs.

We reviewed 35 comment cards completed by patients who attended the practice ahead of our visit. 33 of the comments on the cards were extremely positive. Patients told us the reception staff were polite and helpful, the building was always clean and tidy and they were treated with respect. We were also told the clinicians listened and supported patients. Patients also told us that they could easily access appointments at times to suit them.

Outstanding practice

- Weekend surgeries, with regular clinical staff, were used to provide clinics for monitoring patients with long term conditions as well as for regular appointments.

The Practice Northumberland Avenue & Luker Road

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, and a GP.

Background to The Practice Northumberland Avenue & Luker Road

The Practice Surgeries Limited provides primary medical services to approximately 4200 people over two sites, Northumberland Avenue, and Luker Road Southend on sea in Essex. The practice holds an APMS contract to provide primary medical services. There were two salaried GPs, one female and one male, and regular locum GPs, a nurse practitioner, two nurses, and a healthcare assistant.

The practice had opted out of providing out-of-hours services to the people registered at the practice. Details of how to access these services were available in the practice, in the practice leaflet, and on their website.

The practice opened in 2006 and had no registered patients; it gradually built up the surgery population and staff. When this provider was registered to provide services at this location it took the practice on from another provider.

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

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

How we carried out this inspection

Before we inspected the practice, we reviewed a range of information we held about the practice and asked other organisations and healthcare professionals that work with the practice to share with us what they knew.

Detailed findings

We carried out an announced inspection on 05 November 2014. During our inspection we spoke with a range of staff including GPs, the practice manager, the practice nurses, reception and administrative staff. We also reviewed comment cards left by patients who shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. We also spoke with patients who used the service during the day of the inspection. We observed how patients were cared for and talked with carers and/or family members and reviewed practice records. We observed how staff dealt with patients over the telephone and we discussed patient care planning.

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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, and incident reports recorded on the practice's system and minutes of meetings where incidents were discussed for the last year. We saw the quarterly reports sent to the provider as evidence incidents recorded, analysed and reviewed by both the practice and the provider. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

We saw that there were no complaints raised regarding patient safety on the comment cards we had left for patients to complete and no issues were raised regarding safety with patient care.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last eight years and we were able to review these. Significant events were a standing agenda item on the provider meetings where actions from past significant events and complaints were discussed and learning re-enforced. There was evidence that the practice had learned from the outcome of the significant event reviews and that the findings were shared with the relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used provider incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken which we saw.

National patient safety alerts were disseminated by the practice manager to the appropriate clinical and administrative 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 were able to confirm the system used at the practice to deal with these alerts and record the actions taken. We were shown the evidence that all alerts relevant to the practice had been dealt with.

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. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of office hours. Contact details were easily accessible.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. They had had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. The lead role included promoting staff awareness of safeguarding and communication with other healthcare professionals who linked with the practice regarding these issues. The practice demonstrated good liaison with partner agencies such as the police and social services.

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 and siblings where abuse may have been reported within the family. We saw that appropriate codes were added to the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly identified and were reviewed.

There was a chaperone policy in operation within the practice. A chaperone is a person who is present during an examination of a patient as well as the clinician carrying out the examination. All patients (male and female) are

entitled to have a chaperone present when an intimate examination or procedure will take place. There were notices visible on the waiting room noticeboard informing patients of the chaperone service. 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. Medical staff told us they offered the service before any physical or intimate examination, the offer, acceptance, or decline was recorded.

The practice monitored the emergency admissions made to local hospitals and reviewed all unplanned admissions or readmissions for patients over 75 years of age. In addition, we found the practice monitored the mental health needs of patients to ensure they could access services and were supported throughout their care.

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 medicines management policy, which staff followed, for ensuring that medicines were kept at the required temperatures. This policy described the action to take in the event of a potential power failure.

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 audits in response to a review of prescribing data. For example, an audit of medicines given to treat diabetic 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 evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

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 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. Relevant staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice and provider meetings showed that the findings of the audits were discussed and action taken where there were issues.

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, spillage kits for bodily fluid spills and a current clinical waste disposal contract.

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

The practice had, tested for legionella (a germ found in the environment which can contaminate water systems in buildings). Practice records confirmed the regular checks in line with the practice infection control procedures, to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments

and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the blood pressure monitoring machines.

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

Staff told us there were 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, calculated on their expected need and agreed by the provider at their meetings.

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 the practice manager was the identified health and safety representative.

Identified risks were included on a risk log. Risks were assessed and any actions needed recorded to reduce and manage the risk. We saw that any risks were discussed at practice and provider meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

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). Staff members, knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available at the practice and staff knew their location. These included those for the treatment of cardiac arrest, anaphylaxis and 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. Risks included the lift not working to the first floor practice reception. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with discussed their 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. 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 GP told us they led in specialist clinical areas and the nurse practitioner and practice nurses supported the GPs with long term condition work, which allowed the practice to focus on specific conditions. Medical staff we spoke with told us they supported one another and were open about asking for and providing colleagues with advice.

The practice had reviewed case notes for patients with diabetes to ensure they were receiving appropriate treatment and regular review. The practice used the computer medical records to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

The GP referral rates to secondary and other community care services for all conditions were in line with others in the area. The GPs we spoke with used national standards to refer patients for example, those patients suspected of having cancers referred and seen within two weeks. We saw there were regular reviews of elective and urgent referrals, via audits of consultations and the outcomes. The learning and improvements to the practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. While talking with the GP they 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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice meet their provider contract targets and check the safety and quality of their patients.

The practice audited their disease registers to ensure they could offer treatment review appointments that would be appropriate for their patients. The GP told us 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 diabetic medicines. Following this clinical audit, changes to treatment were made where needed and the audit repeated to ensure outcomes for patients had improved.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had achieved above the local average for the percentage of patients with diabetes who had received an annual medication review. In addition the practice had met all the minimum standards for QOF in coronary heart disease, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team had made use of audit tools, clinical supervision and staff meetings to assess the performance of service at the practice. Staff spoke positively about the culture in the practice around quality improvement.

There was a protocol for repeat prescribing which was in line with locally agreed prescribing guidelines. 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 such as diabetes and that the latest prescribing guidance was being used. The computer medical records identified relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Good

Are services effective?

(for example, treatment is effective)

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed training records and saw that all staff were up to date with attending training required by the provider, courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had 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 General Medical Council can the GP continue to practise and remain on the performers list with NHS England

We found that the provider that held the contract for the practice provided a consistent staff induction programme for staff employed in their practices. 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; information governance, basic life support, automated emergency defibrillation (AED), fire awareness, infection control, child protection, equality and diversity, health and safety, manual handling, and safeguarding of vulnerable adults. Future training and development assessments were made during staff performance plan reviews.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example; administration of vaccines, cervical cytology monitoring for asthma, diabetes, heart disease, strokes, and blood pressure checks. We saw evidence that nursing staff had received the appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support those patients with more complex needs. There were processes in place for the receipt and dissemination to clinicians of blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service received both electronically and by post. The practice had a protocol 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 saw these documents and results, and was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and had sent information regarding working with others services prior to our visit explaining the usefulness of such meetings as a means of sharing important information.

Information sharing

The practice used 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 worked well and they supported patients when it was needed.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). We found that there was information provided to patients at registration on the NHS Care Data programme. This related to the sharing of health information with other

Good

Are services effective?

(for example, treatment is effective)

healthcare providers, with the aim of improving patient outcomes. We saw that the practice had provided a clear explanation and shown that patients could make a choice about agreeing to this proposal.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Information regarding the immunisations received at the practice was shared with the vaccination programmes to ensure that patients' status and entitlement were recorded. Vaccination history status is often required by patients before travel, before being accepted into work or education.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004, and Gillick, with their duties in fulfilling this legislation. The clinical staff we spoke with understood the key part of the legislature regarding specific scenarios where capacity to make decisions was an issue for a patient. Gillick is a competency test that is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The work being undertaken to support the enhanced service to identify 2% of at risk patients and avoid unplanned admissions to hospital required the practice to agree a care plan with those patients identified as at risk. The plans were signed by the person and kept at their home to inform visiting healthcare professionals of their wishes, and recorded on their records at the practice.

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 and had a section stating the patient's preferences for treatment and decisions.

There was a practice policy for documenting consent for treatment and use of patient information. For example consent to send patients a text message to their mobile phone, for written consent for all minor surgical procedures, and even a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the 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 to 25 years and offering smoking cessation advice to smokers. The GPs at the practice were conscious of the local level of deprivation which was above the average for England, and the impact this may have on their patients.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and offered them an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. We were told the smoking cessation clinic had much better access at the practice than a previous practice by a patient we spoke with during our visit. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The nurses at the practice ran a variety of clinics that included; asthma, respiratory disease management clinics, diabetes management, family planning/contraception hypertension management. Patients were followed up if they had risk factors for disease identified at the health check and scheduled for further investigations.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had systems in place to identify people aged over 75 years; each person

Good

Are services effective?

(for example, treatment is effective)

had a named accountable GP in line with the recent GP 2014 to 2015 contract changes. The practice showed us they had an excellent uptake of flu vaccinations for patients 75 years and over. They had also encouraged the uptake for the shingles vaccination.

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 of 2013/2014, a survey of 400 patients that had been undertaken. The evidence from this survey showed, 99% of patients were satisfied that they were treated with compassion, dignity and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were extremely positive about the service they experienced. Patients said they felt the practice offered an excellent service and both medical and reception staff were helpful and caring. They said staff treated them with dignity and respect. Only two comments were less positive but there were no common themes to these. We also spoke with six patients on the day of our inspection. All told us they were more than happy with the care provided by the practice and said their dignity and privacy was respected. Each person we spoke with was keen to express to us why they thought the practice was good at responding to their particular needs.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / 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.

When asked, staff reported there had been no concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected.

There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour, and within the patient information leaflet.

The practice manager told us that staff members understood those patients whose circumstances may make them vulnerable and those living with poor mental health may need to be responded to appropriately to ensure they did not feel discriminated. We noted staff members had undertaken equality and diversity training to reinforce this understanding.

Care planning and involvement in decisions about care and treatment

The patient survey information 2013/2014 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 99% of practice respondents said the GP involved them in care decisions and 99% felt the GP was good at explaining treatment and results.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also extremely positive and confirmed these views.

Staff told us that translation services were available for patients who did not have English as a first language.

The care plans for at risk patients were agreed and signed by the person and kept at their home to inform visiting healthcare professionals of their wishes, and recorded on their records at the practice.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection told us they thought there was plenty of information for carers in the waiting room available to support people, and pointed to the area specifically for carer's information. The comment cards we received confirmed the practice supported their patients with treatment, care, information or referrals appropriately to meet patients and carers needs.

Good

Are services caring?

Notice and leaflets in the patient waiting room, detailed information on how to access support groups and organisations. The practice staff recorded onto the computer records system an alert if a patient was 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 manager told us that consideration for patients being carers, working age or having a young family, was taken into consideration when setting up disease management clinics.

The practice manager told us that if families had suffered bereavement, their usual GP contacted them.

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. Since the practice had been set up in 2008, the staff working there (regardless of the provider that owned the contract for the services) had made a dedicated effort to ensure patients' individual needs and preferences were central to the planning and delivery of tailored services.

The practice had an excellent understanding of their population demographics and their specific health and social needs. One of the ways the practice gathered the information they needed was by auditing their disease registers to ensure they could offer treatment review appointments that would be appropriate for their patients. This was shown by the availability of clinics for chronic disease management, and health monitoring, held at times of the day that patients of working age, patients with caring responsibilities, and families with young children could attend. The practice also held extra clinics at the weekends to ensure they could meet all their patient's needs.

We found the practice had introduced positive service improvements for their patients that were over and above their contractual requirements. This included opening on a Saturday and Sunday to provide services seven days a week. People could access appointments and services in a way and at a time that suits them. For example bookable appointments with a regular doctor (not a locum) at the weekends, showing this was not just an emergency service. This included clinics to monitor long term conditions.

Tackling inequity and promoting equality

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

The practice had access to online and telephone translation services for patient that did not have English as their first language.

The practice provided equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training, and training records confirmed this.

The practice was situated on the first floor of the building with services for patients all on this floor. There was lift access to the first floor. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence. The front door had a call button with a screen at the front of the building if the lift was out of order so reception could be notified and were able to hear and see the patient. There was access to a treatment room on the ground floor if this was necessary.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams, and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including adaptations for baby changing facilities.

Access to the service

Appointments were available during the practice open hours from 8am to 6.30pm and to 8pm twice a week and 7.30pm once on weekdays. The practice was also open to see patients on Saturday between 12 noon and 3pm and on Sunday 10am to 1pm.

Comprehensive information was available to patients about appointments on the practice website and within the patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them for example older people and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes to those patients who needed one. Appointments were available outside of school hours for children and young people, and the premises were suitable for children and young people. Services and appointments reflected the needs of working age people with extended opening hours, online booking system, online or telephone consultations where appropriate, and support to enable people to return to work. We found partnership working to understand the needs of the most vulnerable in the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice population, with flexible appointments for those that need them. Patients with mental health needs within the practice population including those within hard to reach groups were monitored, kept informed of service provision, and time appropriate appointments were available for those that needed them.

Patients commented positively about the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. Over 93% of patients said they found it very easy or fairly easy to get through to the practice on the telephone.

The practice's extended opening hours on Tuesday, Thursday evening until 8pm and Friday evening until 7.30pm was particularly useful to patients with work commitments during the week. In addition the availability of appointments on Saturday and Sundays. This was confirmed by the comments on completed CQC comment cards received on the on the day of inspection.

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 was in place, a notice was displayed in the waiting room; information was also available within the patient information leaflet and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the previous 18 months and found these were dealt with appropriately in line with the practice policy and procedure and in a timely way. The practice showed openness and transparency when with dealing with their complaints. The practice reviewed complaints to detect themes or trends, and this was discussed with the provider that held the contract for the primary care services. Anonymised complaints were also discussed and reviewed at Patient Participation Group meetings to ensure patients could be involved in the review. We looked at the report for the last review and found there were no themes arising out of the complaints the practice had received.

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

We saw that the practice had a vision statement within their practice leaflet 'Patients come first'. This outlined their aim to deliver genuinely caring and patient-centred services.

We also saw the practice's 'statement of purpose' which listed their aims and objectives for the service. These were: 'To be committed to the needs of our service users, provide a consistently high standard of medical care. Engage other professionals in the care of our patients and promote healthy lifestyle and to ensure safe and effective services and environments for staff and service users. To ensure the continuous improvement of healthcare services through excellent engagement and positive response to feedback from service users. To continually educate, develop and motivate our staff.

To treat all of our service users with dignity and respect and to deliver a high quality service that improves the health of the practice population as a whole. The service we deliver will be clinically sound and will reflect advances in Primary Care wherever possible.

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. All 10 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 there was a GP lead for safeguarding. We spoke with three 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.

Governance arrangements were overseen by the provider; this included the systems that governed serious incidents, complaints and practice risks. Reports were run on a monthly basis and the status checked to ensure work was completed appropriately and in a timely fashion.

We saw the practice had achieved an overall level two for information governance using the 'information governance (IG) toolkit'. The IG toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health IG policies and standards. It also allows members of the public to view participating organisations' IG toolkit evaluations. Level two is a satisfactory achievement for primary care services using this toolkit.

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.

Leadership, openness and transparency

The practice leadership was overseen by the practice manager and overseen by the provider. The staff followed the corporate documentation used by the practice. We found this to be up to date and recently reviewed. The practice had a patient participation group (PPG) and we were told they met regularly with the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG chair told us how the practice manager always kept the group up to date with the work going on in the practice and the local community at the meetings. We were told the group really valued this information. The group was focused and pragmatic in their work with the service and concentrated on the provision of accessible and sustainable services. This was evident with the practice and PPG's commitment to operate accessible opening hours enabling patients to attend and receive care and treatment to meet their individual needs. The PPG told us they felt they were listened to and valued by the practice manager and staff. We were also told by the PPG that the practice manager was extremely well thought of by staff and patients. They told us the practice manager was known for addressing issues as soon as requested and for being both respectful of patient choices and responsive to their individual needs. The provider was also well regarded by the PPG as they had met with them and explained their commitment to providing an excellent service for patients when they took over the contract.

Staff felt supported by the practice manager and GP. They told us they would not hesitate to raise concerns and felt confident they would be well received and acted upon. We

Are services well-led?

Good

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

found a whistle blowing policy was available to staff. Staff were aware of the policy and would know what to do if needed. We found it was up to date and had been regularly reviewed.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, and complaints received. We looked at the results of the annual patient survey and over 93% said that they found it very easy or fairly easy to get through to the practice on the telephone. This showed a positive response to work done to improve telephone access to the practice.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG and the practice met quarterly, actions agreed from these meetings and the minutes were available on the practice website.

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. Staff knew how to access the information from the handbook electronically and told us they would check with the practice manager if they had an issue.

Management lead through learning and improvement

Staff told us that the provider organisation that owned the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three 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 we saw certificates of completed training to evidence this.

The practice had completed reviews of significant events and other incidents and shared the learning with staff at provider meetings to ensure the practice improved outcomes for patients.