Grove Park Terrace Surgery

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Grove Park Terrace Surgery on 18 November 2014. We rated the practice as 'Requires Improvement' for the service being safe, and 'Good' for the service being effective, caring, responsive to people's needs and well-led. We rated the practice as 'Good' for the care provided to older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

We gave the practice an overall rating of 'Good.'

Our key findings were as follows:

- Patients reported good access to the service. They were satisfied with their overall experience of making appointments that were convenient for them.
- Patients said they were treated with dignity, respect and compassion. They said that they were supported through periods of serious illness and bereavement.
- The practice had a good track record on safety and some systems in place to manage safety including procedures for reporting incidents and safeguarding concerns.
- The practice learnt when things went wrong and shared learning with all staff to minimise the risk of reoccurrence.
- The practice understood the needs of its patients and provided services that met their needs.
- The practice had strong leadership and staff were supported to deliver effective care.

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

Importantly, the provider must:

- Carry out regular infection control audits to ensure infection control standards are maintained.

Summary of findings

- Carry out a Legionella risk assessment to assess the risks associated with Legionella (a bacteria found in the environment which can contaminate water systems in buildings).

In addition the provider should:

- Formalise a business continuity plan to ensure continuity of care for patients in the event of a major disruption to the service.
- Provide staff with access to and training in the use of an automated external defibrillator (used to attempt to restart a person's heart in an emergency) in line with the Resuscitation Council (UK) recommendations for primary care.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. However, health and safety monitoring was limited. We found that regular infection control audits had not been carried out to ensure infection control standards were maintained and a Legionella risk assessment had not been carried out to assess the risks associated with Legionella (a bacteria found in the environment which can contaminate water systems in buildings).

Are services effective?

Good

The practice is rated as good for providing effective services.

NICE guidance was referenced and used routinely by the GPs. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' mental capacity and the promotion of good health. We found that multidisciplinary team meetings were not held however there was a limited need for multidisciplinary care. Staff had received training appropriate to their roles to deliver effective care to patients. The practice had completed appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services.

National patient survey data showed that patients rated the practice well most aspects of care. Patients said they were treated with compassion, dignity and respect. They felt cared for, supported and listened to by staff. Patients said that the clinical staff involved them in decisions about their care and treatments. This was also reflected in other sources of data we received. The practice supported patients through periods of bereavement and the diagnosis of serious illness.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported they could get appointments to suit them with urgent appointments usually available the same day. This aligned with the national patient survey and the practices' internal patient survey where patients rated the practice well in relation to access. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with all staff.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a mission statement and staff were clear about the practices' vision and strategy and their responsibilities in relation to this. There was a clear leadership structure and staff reported that they were supported by the management team. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were some systems in place to monitor and improve the quality of the service and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

The practice had a low number of older patients with only 3% of patients being over 65 years of age. However we found the practice delivered satisfactory care to older patients when appropriate. For example all patients over 75 years of age had a named GP who looked after their care and treatment. The practice had also developed care plans for older patients who were at risk of unnecessary hospital admission. The practice did not hold meetings with other health care professionals to provide multidisciplinary care for older patients however the clinical team did liaise with the appropriate health care professionals when required to ensure older patients received effective care. The GPs provided home visits to those older patients who were housebound and unable to attend the practice.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

We found that annual reviews were carried out on patients with long-term conditions. The practice offered diabetes clinics on Thursday mornings for anyone identified with raised blood glucose levels (those at risk of diabetes). Patients were given lifestyle and dietary advice and this clinic was accessible to all at risk patient's resident within the CCG area. The clinic was nurse led and run in collaboration with the GP partner who had a special interest in diabetes.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

There were a large number of children registered at the practice. Staff recognised and responded to the needs of families, children and young people on a daily basis. There were appropriate safeguarding procedures in place, staff were trained and aware of how to raise any concerns. Childhood immunisations were offered by the practice nurses. The GPs offered family planning advice and both GPs prescribed the contraceptive pill. The senior GP and the nurse practitioner had recently completed additional training in sexual health and cases were discussed in practice meetings. The female GP partner had a diploma in family planning.

Summary of findings

Working age people (including those recently retired and students)

Good

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

The practice provided access to the practice for working age patients through the introduction of extended hours. Patients could also access consultations via the telephone. Routine health checks were offered to patients between 40 and 75 years of age and a flu clinic was accessible on Saturday mornings. Online services were available for booking appointments and ordering prescriptions via the practice website.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable.

Patients with drug and alcohol issues were referred to local support services and a GP had completed a substance misuse course to enable them to identify patients with these issues. Care plans had been developed for patients with learning disabilities and they had received annual physical health checks. Practice staff had access to an interpreter and translation service via language line to ensure patients whose first language was not English could access the service. Staff were able to demonstrate sufficient knowledge in the area of safeguarding vulnerable adults, what to look for and how to report any concerns. The practice was accessible to disabled patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia).

Care plans had been developed to deliver effective care for patients on the mental health register and those with dementia. The GPs liaised with the local mental health team when required and had a basic understanding of the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

We spoke with seven patients during the course of our inspection. We reviewed eight completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service, the results of the practices most recent patient experience survey where 75 out of 100 patients surveyed responded, and the 2014 national GP patient survey where 109 out of 406 patients surveyed responded. The evidence from all these sources showed that patients were satisfied with their GP practice.

Areas for improvement

Action the service MUST take to improve

- Carry out regular infection control audits to ensure infection control standards are maintained.
- Carry out a Legionella risk assessment to assess the risks associated with Legionella (a bacteria found in the environment which can contaminate water systems in buildings).

Action the service SHOULD take to improve

- Formalise a business continuity plan to ensure continuity of care for patients in the event of a major disruption to the service.
- Provide staff with access to and training in the use of an automated external defibrillator (used to attempt to restart a person's heart in an emergency) in line with the Resuscitation Council (UK) recommendations for primary care.

Grove Park Terrace Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Grove Park Terrace Surgery

Grove Park Terrace Surgery is situated at 25 Grove Park Terrace, Chiswick, W4 3JL. The practice provides primary care services through a Personal Medical Services (PMS) contract to 3200 patients in the local area. The practice is part of the NHS Hounslow Clinical Commissioning Group (CCG) which is made up of 54 GP practices that serve a population of 288,000. The practice serves a young population group with patients predominantly in the 30-45 years age range. Twelve percent of patients are children under five years of age which is double the national average and only 3% over 65 years of age. The practice population is predominantly (83%) white middle class with some ethnic minorities including patients of Somali and Arabic origins. The practice scores medium to low in terms of the levels of deprivation. However, there is a high prevalence of diabetes, asthma and hypertension in the local population. The practice staff comprises of a female GP who is the registered provider, a male salaried GP, nurse practitioner, practice nurse, health care assistant, practice manager and a small team of receptionist/administration staff. The practice is a training practice and has two GP registrars undergoing training. Patients are referred to the NHS 111 service for out of hours care.

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

The practice offers a range of clinics and services including well-person health checks, contraception, cervical smears, immunisations, travel vaccinations, blood tests, sexual health, blood pressure monitoring and diabetes and asthma checks. The practice also offers walk-in flu clinics on Saturday mornings and diabetic research clinics open to patients within the Hounslow CCG who had been identified as being 'at risk' of developing diabetes. Minor surgery and Intrauterine Contraceptive Device (IUCD) fitting is also offered.

The CQC intelligent monitoring placed the practice in band five. 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.

Why we carried out this inspection

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

Detailed findings

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. This provider had not been inspected before and that was why we included them.

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 such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 18 November 2014. During our visit we spoke with a range of staff including two GPs, a trainee GP, the practice nurse, health care assistant, practice manager and a receptionist and spoke with seven patients who used the service. We reviewed eight completed Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of nine significant events that had occurred since May 2011 and these were made available to us. Significant events were discussed at practice meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, one such incident involved the wrong medicine being prescribed to a patient. The practice informed the safety department of the company supplying the medicine and were told that there was no significant risk. The patient was also informed and their medicine was changed. The practice learnt to be more careful in the future by reviewing and improving their processes and procedures.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding children and adults. The GPs were trained to Level 3 in child protection, the nurses to Level 2 and non-clinical staff to Level 1. All staff had completed vulnerable adults training including training in domestic violence issues. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as the practice lead in safeguarding vulnerable adults and children. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments for example, children subject to child protection plans. A chaperone policy was in place and the policy was displayed in the waiting area of the practice informing patients a chaperone could be arranged on request. Chaperone training had

been undertaken by the nurse and the health care assistant and we were informed that non-clinical staff did not carry out chaperoning duties. Criminal checks via the Disclosure and Barring Service (DBS) had been completed on staff who acted as chaperones.

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

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the

practice staff, and the action to take in the event of a potential failure was described.

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 relevant regulations. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support in their role, as well as updates in the specific clinical areas of expertise for which she prescribed, which included antibiotic and statin (a medicine to reduce cholesterol) prescribing.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, the training requirements of staff generating repeat prescriptions and

how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Repeat prescriptions could be ordered on the practice website or in person and

were available within 48 hours. Prescription pads were stored safely in locked drawers. Patients we spoke with raised no concerns about the management of their prescriptions.

Cleanliness and infection control

Patients we spoke to were satisfied with the standards of cleanliness and the practice was clean and tidy on the day of our inspection. The practice nurse was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received training about infection control specific to their role in practice meetings. However, we found that regular infection control audits had not been carried out to monitor infection control standards. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury however the policy was not displayed as a quick reference for staff in the event of a needle stick injury. Cleaning schedules were in place for both the clinical and non-clinical areas of the practice. The GPs and nurse was able to describe the routine for cleaning the consultation rooms between patients. Waste was stored appropriately and disposed of by a professional waste company. The practice had not carried out a Legionella risk assessment to assess the risks associated with Legionella (a bacteria found in the environment which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was within the last twelve months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, fridge thermometers and blood pressure monitors.

Staffing and recruitment

We reviewed the recruitment records of a cross section of staff. These contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

There was an adequate number of clinical staff to meet patients' needs. There was a full time GP partner and a salaried GP covering six sessions per week. The practice manager told us the practice had a buddy system with another local practice to cover GPs in urgent situations, for example short notice leave or sickness therefore locums were rarely used. The buddy system was also useful to cover GPs who were on annual leave. There was a nurse practitioner in post three mornings per week and a practice nurse two evenings per week. A health care assistant was also in post with appointments available on Mondays and Wednesdays.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy in place and the practice manager, who was the health and safety lead, had completed a qualification from the Institute of Occupational Safety and Health (IOSH). However we found health and safety monitoring was limited. We found there was a fire risk assessment which had been reviewed in September 2014, any areas identified for improvement had been addressed. However, the practice could not provide evidence of other health and safety monitoring such as audits to ensure infection control standards were maintained or a Legionella risk assessment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support in the previous 12 months. Emergency equipment was available including access to oxygen and anaphylaxis kits. All staff asked knew the location of this equipment and records we saw confirmed

Requires improvement

Are services safe?

these were checked weekly. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and had not completed an assessment of the risks associated with not having access to one. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included emergency medicines for the treatment of anaphylaxis and myocardial infarction.

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.

The practice had not developed a business continuity plan to deal with foreseeable emergencies that could impact on the daily operation of the practice. For example, flood, fire or power failure. A fire risk assessment had been undertaken and staff had been trained in fire evacuation procedures.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE), local commissioners and the Royal College of General Practitioners (RCGP). Guidelines were accessible via the computer system for staff to view and updates were discussed between the GPs at clinical meetings. All the GPs were up to date with their continual professional development. We found from our discussions with the GPs that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, patients with complex needs and those managing long-term conditions.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD), hypertension and asthma. The practice nurses supported this work which allowed the practice to focus on patients with these specific conditions. Annual reviews were carried out on all patients with long-term conditions. For example the practice had carried out annual reviews of 76% of asthma patients and had reviewed the blood pressure of 69% of patients with hypertension in the current year.

The practice referred patients to secondary care and other community care services in line with national guidance including urgent two week wait referrals for suspected cancer. The practice performed well in terms of referrals. For example, data showed that referrals to secondary care for all conditions were below the Clinical Commissioning Group (CCG) average. The practice had double the national average of children under 5 years. However, paediatric referrals were also below the CCG average which showed the practice was delivering effective care and treatment to children. The practices' antibiotic prescribing was in line with the CCG average.

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

Management, monitoring and improving outcomes for people

The practice had achieved 95.4% in their Quality and Outcomes Framework (QOF) performance in the year ending April 2014 and 70% so far in the current QOF year. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. There was a lead GP responsible for QOF and the practices' performance was an agenda item discussed at meetings which helped the practice to focus on areas where services to patients could be improved. The practice had achieved 100% in most disease areas for QOF in the previous year apart from diabetes where the practice had scored 92.5% which was below the CCG and national averages. The practice were working to improve outcomes for patients with diabetes and was providing weekly diabetic clinics.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included ear, nose and throat referrals to secondary care, accident and emergency attendances, cervical smears and hypnotic (a class of medicines used in the treatment of insomnia) prescribing. Improvements had been made to clinical practice as a result of audit. For example, to reduce hypnotic prescribing the practice had implemented measures to review all patients prescribed hypnotic medicines and consider alternative treatments for them where appropriate. Two of the audits we viewed were completed audit cycles in that the audits had been repeated to monitor improvement.

The practice 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 was performing well when compared to other practices in the area in terms of referral rates for all conditions. The practice was performing in line with other practices within the CCG in terms of antibiotic prescribing. The practice participated in peer review with other practices in the CCG which was carried out through monthly network meetings.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a

Good

Are services effective?

(for example, treatment is effective)

section stating the patient's preferences for treatment and decisions. The practice kept records and showed us that all patients with learning disabilities had care plans in place and these had been reviewed in last year.

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 mandatory courses such as annual basic life support, infection control, safeguarding vulnerable adults and children. Staff had also been trained in more specialised topics such as female genital mutilation, domestic violence issues and sexual health. We noted a good skills mix amongst the doctors with the GP partner having a special interest in diabetes and a Diploma of the Faculty of Family Planning (DFFP). The GPs were licenced by the General Medical Council (GMC) and the nurses registered with the Nursing and Midwifery Council (NMC). One of the nurses was a nurse practitioner. The health care assistant had completed a National Vocational Qualification (NVQ Level 3). The practice manager had an Institute of Occupational Safety and Health (IOSH) qualification in health and safety. All staff had received induction training when they started working for the practice.

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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training for relevant courses, for example training in cytology. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive. Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and when carrying out cervical smears.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received electronically and by letter or fax. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. Staff told us that there were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice did not hold multi-disciplinary team meetings with other health care professionals and service providers to plan care for patients with more challenging needs. The GP partner told us that this was because the practice had very few patients requiring this level of input and meetings would not be time efficient. We saw evidence that this was the case. At the time of our inspection the practice had no patients on the palliative care register and only three patients with complex needs. However, we did find that the practice liaised with the district nurse, mental health team, McMillian nurses and primary care navigators when this was required.

Information sharing

Patients were referred to other services/specialists through on the day referrals by the GP's. We found the practices referral process was efficient and in line with national guidelines. Patients we spoke with had no issues with the referral process. They said the GP's always referred them promptly. The practice had systems in place to provide staff with the information they needed. An electronic patient record (SystmOne) was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to

Good

Are services effective?

(for example, treatment is effective)

describe how they would be implemented in their practice if needed. For example, when carry out mental capacity assessments for patients who lacked capacity to make decisions relating to their treatment and care.

GPs demonstrated an understanding of both Gillick and Fraser guidelines (legislation used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge) however the GPs we spoke to told us they had not needed to use them.

Patients with learning disabilities and those experiencing poor mental health were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us 90% of care plans for patients on the mental health register had been reviewed in last year and all 14 patients with learning disabilities had a care plan review.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. The practice also offered health checks for patients aged 40 -75. We noted a culture amongst the GPs, nurses and the health care assistant to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25, weight management advice to patients experiencing weight problems and smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all the patients on the register had been offered an annual physical health check. Practice records showed that all patients with learning disabilities had received a check up in the last 12 months. The practice had provided smoking cessation advice to 94% of patients identified for advice through health care assistant led smoking cessation clinics. HIV testing was offered to patients on registration with the practice in line with national guidelines.

The practice's performance for cervical smear uptake was 82% in the previous year which was in line with CCG averages and the practice had achieved 80% uptake so far in the current year. Cervical smear audits were carried out every two years in accordance with the requirements of QOF and the number of inadequate smears monitored. Text reminders were sent out to follow up on missed smear test appointments.

The practice offered a full range of immunisations for children, travel vaccines including yellow fever and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with CCG averages. The practice offered Saturday clinics for flu vaccinations and had provided vaccinations for 47 out of 64 diabetics identified as 'at risk' from seasonal flu. The practice offered diabetes clinics on Thursday mornings for anyone identified with raised blood glucose levels (those at risk of diabetes). Patients were given lifestyle and dietary advice and this clinic was accessible to all at risk patient's resident within the CCG. The clinic was nurse led and run in collaboration with the GP partner who had a special interest in diabetes. The GPs offered family planning advice and both GPs prescribed the contraceptive pill. The GP partner and the nurse practitioner had recently completed additional training in sexual health and cases were discussed in practice meetings.

A wide range of information was displayed in the waiting area of the practice and on the practice website to raise awareness of health issues including information on cancer, meningitis in children, flu and measles. Services were also advertised such as diabetic screening, and local dental services.

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 practices' annual patient satisfaction survey last carried out between December 2013 and March 2014. We spoke to seven patients during our inspection and also reviewed eight Care Quality Commission (CQC) comment cards completed by patients prior to our inspection. The evidence from all these sources showed patients were satisfied with their GP practice. For example the results of the national patient survey showed that 91% of respondents described their overall experience of the practice as 'good' and 88% would recommend their GP practice to someone new in the area. Both these results were above the CCG average. These results were also aligned with the practices' internal patient survey which showed that 84% of respondents were 'very happy' with their overall treatment at the practice.

All seven patients we spoke with said that they were treated with respect, dignity and compassion by the practice staff and this was also reflected in the comment cards we reviewed. Patients said the care was excellent, compassionate and staff were friendly, professional and accommodating. This evidence aligned with the patient surveys. For example national patient survey data showed that 95% of respondents found the receptionists helpful, 79% said the GPs were good at treating them with care and concern and 75% were happy with the level of privacy when speaking to the receptionists. These results were above the CCG average. The practices' internal survey was also positive and showed that 98% of respondents felt that reception staff treated them well, 92% felt listened to by the GPS and 92% felt very at ease during consultations. During our inspection we observed consultations and treatments being carried out in the privacy of the consultation rooms with doors closed to ensure conversations could not be overheard. We noted that curtains were used in the consultation rooms during treatments and consultations.

Care planning and involvement in decisions about care and treatment

The results of the national patient survey showed that 74% of respondents said the GPs were good at explaining tests and treatments and 69% said the GPs were good at involving them in decisions about their care. The results for the nurses explaining tests and treatments and involving patients in decisions about their care were 72% and 62% respectively. All these results were above the CCG average and were aligned with the practices' internal survey where 87% of respondents said that the GPs involved them in decisions. Patients told us that the GPs always explained things and gained their consent before commencing any treatment. Patients said that clinical staff sought their consent before carrying out physical examinations. GPs we spoke with were able to demonstrate an understanding of Gillick guidelines used to help clinicians decide whether a child under 16 years has the legal capacity to consent to medical examination and treatment without the need for parental permission or knowledge. We also saw evidence that consent was sought for minor surgical procedures.

An interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with during our inspection and comment cards received highlighted that staff responded compassionately when patients needed help and supported them when required. One patient said they had seen the same GP for over 13 years and were supported through a miscarriage. They said the GP was very supportive, professional and compassionate. The GPs told us that they telephoned patients who were going through a period of bereavement and patients who had been recently diagnosed with cancer, to offer their support. Leaflets were available in the waiting area with the contact details of organisations that provided end of life and bereavement support. The practice had a carers register and carers were signposted to support agencies to help them cope with their role.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used the BIRT (Business Development & Reporting Tool), which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities. The practice had analysed information sourced from Public Health England in relation to the practice population. For example a high proportion of patients were of working age and to meet their needs the practice had extended its opening hours so patients could get an appointment outside working hours. The practice was also providing Saturday clinics for influenza vaccinations to meet the needs of working age patients. The practice also engaged with the CCG and other practices in the local area on a monthly basis to discuss local needs and service improvements. For example the practice was in discussions as to how access to services could be extended further. Staff had been trained in female genital mutilation to meet the needs of patients affected by this and weekly diabetic clinics were run to meet the needs of a high diabetes incidence in the local population.

The practice had a small team of staff and there had been very little turnover of staff in the previous two years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This included appointments with a named GP for older patients, patients with learning disabilities and those experiencing poor mental health. The practice had also developed care plans for these patients to reduce unnecessary hospital admissions. The results of the practices' internal patient survey showed that 83% of respondents said they could get to see the GP of their choice easily. However this was not reflected in the national patient survey where only 44% of respondents with a preferred GP usually got to see or speak to that GP which was below the CCG average.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The PPG was made up of eight volunteer patients who met with the practice on a monthly basis to feedback patients' views and opinions. For example the practice had installed a new telephone system to improve telephone access to the reception staff. The practice had also extended consultations with the GPs to 15 minutes as a result of feedback from the PPG.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services for patients whose first language was not English to help them access services offered by the practice. The practice website contained fact sheets written in 20 different languages explaining the role of UK health services and the National Health Service (NHS), to newly-arrived individuals seeking asylum. Issues covered included the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services.

The premises and services had been adapted to meet the needs of people with disabilities including disabled access at the entrance to the practice, a lift for wheelchair and mobility scooter users and modified toilet facilities to accommodate them. The practice carried out home visits for those patients who were housebound and visited one patient who was a resident in a residential care home.

Access to the service

The practice opening hours were 8.00am to 6.30pm Monday to Friday with extended hours on Tuesdays until 8.00pm. Walk-in sessions were available on Wednesday mornings where consultations were available without an appointment. Appointments could be pre booked up to four weeks in advance and emergency appointments were available daily. Patients could access telephone advice between 12.00 and 12.30pm each day and home visits were available for those patients who were housebound. Bookable appointments with the nurse practitioner were available three mornings per week and the practice nurse two afternoons per week. Online services on the practices' website allowed patients to book appointments, order repeat prescriptions and access test results. Information was displayed in the practice waiting room and on the website directing patients to the 111 out of hour's service when the practice was closed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We reviewed the results of the national patient survey which showed that patients were satisfied with access. For example 95% of respondents found it easy to get through by phone, 95% of respondents were able to get an appointment last time they tried, 93% of respondents said the last appointment they got was convenient and 88% described their experience of making an appointment as 'good.' All these results were above the CCG average. This also aligned with the practices' internal patient survey where 88% of respondents were satisfied with the practice's opening hours and ease of getting appointments. Patients we spoke to during our inspection and comment cards received raised no concerns about getting appointments however two patients did comment that sometimes it was difficult to get an appointment on the same day in an emergency.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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 including information on the practice website and information displayed in the waiting area of the practice. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

The practice had received four complaints in the previous year. We reviewed the complaints received and found these were satisfactorily handled and dealt with in a timely way in line with the practice's complaints policy. The practice regularly discussed complaints in practice meetings and complaints were reviewed on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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's mission statement was to provide high quality, safe and effective services for the management of their registered patients. To achieve this aim the practice was focused on providing excellent clinical and person centred care. Staff we spoke with were aware of the mission statement and their responsibilities in relation to it and worked as a close knit team to achieve this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were accessible to staff via the practices' computer system. We looked at a number of these policies and found they had been reviewed annually and were up to date. Policies we reviewed included safeguarding, confidentiality, infection control and medicines management.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice had achieved 95.4% of QOF points available in the year 2013/14 and the practice had achieved 70% so far in the year 2014/15. The practice had a lead GP responsible for QOF and we found that QOF performance was discussed at team meetings and plans put in place to maintain or improve outcomes.

The practice participated in benchmarking and audit. The practice had benchmarked its performance against other practices within the local CCG and was performing well in relation to referral rates, and was performing in line with other practices in relation to antibiotic prescribing. The practice participated in clinical audit and we saw evidence of some completed audit cycles that showed improved outcomes for patients.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example the GP partner was the lead for safeguarding children and adults and the management of diabetes and the salaried GP was the lead for information governance and QOF. The practice nurse was the lead for infection control and medicine management and the practice manager the lead for health and safety and complaints handling. We spoke with four members of staff including a GP registrar who were clear about their own roles and responsibilities. They all told us they felt valued, supported in their roles and knew who to go to in the practice with any concerns.

A variety of meetings took place regularly. For example monthly practice and clinical meetings. The GP partner and the practice manager attended monthly locality meetings with other local practices. CCG meetings were also attended every two months where commissioning issues were discussed and training and clinical updates provided. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings. A GP showed us a board in the staff room where staff were encouraged to write down suggestions for topics/issues to be discussed in practice meetings. Staff said they were listened to and felt supported in their role.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the practices' recruitment and whistleblowing policies. Staff we spoke with knew how to access these policies and the policies had been reviewed on an annual basis. There was also a staff handbook which included information on health and safety and how to access the policies and procedures.

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

The practice had a Patient Participation Group (PPG) comprising of eight volunteers who were patients of the practice. The PPG was representative of the patient population and included ethnic minorities and older patients. The PPG was involved in organising the practices' annual patient survey and met on a monthly basis with the practice to discuss patient's opinions and concerns. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from the survey were available on the practice website. As a consequence of patient feedback the practice had made improvements to the services provided. For example a new telephone system had been installed and consultations with the GPs extended to 15 minutes. The practice also had a suggestion box located at the reception and patients had the opportunity to complete a comments and suggestions form on the practice website.

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 staff records and saw that annual appraisals took place which included a personal development plan detailing staff training needs and timelines for completion. Both clinical and non-clinical staff told us that the practice was supportive of training. For example staff had requested additional training in consent, confidentiality and cytology and as a result training had been provided.

The practice was a GP training practice participating in undergraduate and postgraduate medical education programmes. At the time of our inspection two trainee registrars were undergoing training at the practice. We spoke with one trainee registrar who told us the practice was very supportive. They said the GPs were very good at giving feedback on their performance and areas for improvement.

The practice had completed reviews of significant events and other incidents and shared lessons learnt with staff via meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The registered person did not identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity because regular infection control audits had not been completed to ensure infection control standards were maintained and a Legionella risk assessment had not been carried out to assess the risks associated with Legionella bacteria. Regulation 10.