Highbury Grange Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Highbury Grange Medical Practice on 8 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, caring, safe and responsive services. The service was found to require improvement for providing an effective service. It was also good for providing services 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 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.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and that they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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.

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

Importantly the provider should:

- Ensure a programme of completed clinical audit cycles is undertaken.

Summary of findings

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 report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed. There was enough staff to keep patients safe. The practice had systems in place to ensure patients were safe including safeguarding and chaperone procedures, and processes to ensure medicines were correctly handled. Patients were treated in a clean environment and processes were in place to monitor infection control. Equipment was fit for purpose and maintained regularly.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing an effective service as there were areas that the practice needed to address. Data showed patient outcomes were below average for the locality. National Institute for Health and Care Excellence (NICE) guidance was routinely referenced and used. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received appropriate training for their roles and further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced. The practice was not able to demonstrate completed audit cycles where changes had been implemented and improvements made.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others in the locality for several aspects of care. For example 96% of patients had confidence in the last nurse they consulted, which was above the Clinical Commissioning Group (CCG) average of 95%. Eighty three percent of patients said that the last GP they spoke with was good at giving them enough time, which was above the CCG average of 81% Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with

Summary of findings

kindness and respect ensuring confidentiality was maintained. The practice had an active Patient Participation Group (PPG) which met regularly to discuss practice concerns and to develop the annual patient survey.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the local Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good continuity of care with an accessible named GP. However concerns were raised over the time taken to access the practice for appointments which the practice was addressing. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver a high level of service to patients. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures, including infection prevention and control and medicines management, to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice 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, 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example, 77% of patients had received a flu vaccination. All patients had a named GP and this was recorded within their notes The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For example, the practice had undertaken annual reviews for 78% of patients on the chronic obstructive pulmonary disease (COPD) register and 93% of patients had an agreed care plan. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice ran a nurse led diabetic clinic.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. For example the practice vaccinated 96.2% of children with the MMR vaccination. Patients told us that children and young people were treated in an age-appropriate way and were treated as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies, this included baby changing facilities. We saw good examples of joint working with midwives, health visitors and school nurses.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included extended hour appointments and a nurse led Saturday morning appointments clinic. The practice was proactive in offering online services including online booking. The practice provided a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability and those who needed the support of the interpreting services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The GP also provided a report for the transition of young people in social services care to adult services.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Seventy six percent of patients on the mental health register had an agreed care plan. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. A mental health worker and clinical psychologist attended the practice on a weekly basis to meet with patients.

The practice advised patients experiencing poor mental health how to access support groups and voluntary organisations. It had a

Summary of findings

system in place to follow up patients who had attended accident and emergency (A&E) who may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs including dementia.

Summary of findings

What people who use the service say

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

Patients were happy with the overall service provided and said that they were treated with respect and well cared for. However concerns were raised regarding booking appointments, although it was stated that there had been some improvement recently. Patients told us that they were involved in the decision making process regarding their treatment, and were given information about all the treatment options available to help them make their choices.

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

We viewed the national GP patient survey for 2014 and found that 72% of patients that completed the survey found the overall experience good. The practice scored particularly well in the nurse giving enough time (88%), which was the same as the Clinical Commissioning Group (CCG) average, and patients usually having to wait 15 minutes or less after their appointment time to be seen (63%) which was also higher than the CCG average of 61%. Areas which the practice had poorer scores included patients being able to get through on the telephone to make appointments (55%) compared to the CCG average of 76%. In the latest patient survey carried out by the practice's Patient Participation Group (PPG), 81% of patients who completed the survey were satisfied with the overall service provided by the practice.

Areas for improvement

Action the service SHOULD take to improve

- Ensure a programme of completed clinical audit cycles is undertaken.

Highbury Grange Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Highbury Grange Medical Practice

Highbury Grange Medical Practice is a practice located in the London Borough of Islington. The practice is part of the NHS Islington Clinical Commissioning Group (CCG) which is made up of 38 practices. It currently holds a General Medical Services (GMS) contract and provides NHS services to 8757 patients.

The practice serves a diverse population with many patients attending where English is not their first language. The practice does not have a large older population (5%) and 19% of the population is under the age of 14. The practice is situated within a purpose built health centre and has its own separate entrance. The practice is situated on ground level and consulting rooms are available on one level for those with impaired mobility. There are currently six GPs (three male and three female), four nurses, a healthcare assistant, seven administrative staff and a practice manager.

The practice is open each week day between 9am and 6.30pm except for Wednesday when the practice is open between 9am and 1pm. Appointments are available each morning between 9am and 1pm, and each afternoon except Wednesday between 3pm and 6.30pm. The practice provides an extended hour's clinic on a Thursday between 6.30pm and 8.30pm. Both a GP and a practice nurse are available for the extended hour's clinic. The practice runs a Saturday morning nurse led clinic which offers the cervical smear test service, routine vaccinations and blood tests.

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

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

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

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 8 April 2015, as part of our regulatory functions. This inspection was planned to check whether the provider is

Detailed findings

meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations including Islington Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 8 April 2015. During our visit we spoke with a range of staff including GPs, practice nurse, practice manager and administration staff. We spoke with patients who used the service including representatives of the Patient Participation Group (PPG). We reviewed five completed Care Quality Commission (CQC) comments cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice used reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example an incident occurred where there was an issue with the medicine fridge temperature which resulted in medicines being moved to another facility.

We reviewed the nine safety records and incident reports recorded in 2014 and found these were discussed in practice meetings. This showed that the practice had managed these consistently over time and could evidence a safe track record.

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 two years and we were able to review these. Significant events were a standing item on the weekly practice meeting agenda and a dedicated meeting was held every two months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Staff used significant events forms to record any occurrence and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. For example, we saw evidence of where action was taken as a result of a delay in an urgent referral. The practice reviewed policies to ensure that these referrals were picked up in the future. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken by the practice to prevent it happening again.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff were able to give examples of recent alerts that were relevant to the care they were responsible for. For example an alert regarding the Ebola crisis was disseminated to staff to ensure they understood the procedure to follow. They also told us alerts were discussed in practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to review risks to vulnerable children, young people and adults. All staff had received both safeguarding and child protection training. Safeguarding and child protection training had recently been completed by the staff team in May 2014 and February 2015. Clinical staff had received Level three child protection training and reception staff had received Level one child protection training. We asked members of both the clinical and non-clinical team about the training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibility to report any concerns and how to contact the relevant agencies. Contact details were easily accessible within the practice office. The practice had a dedicated GP lead for safeguarding and staff were aware of this and that they could speak to the GP if they had a concern.

A chaperone policy was in place and information signs were visible in the waiting area and in consulting rooms. Chaperone training had been undertaken by nursing staff and reception staff who were on the practice chaperone list. All staff understood their responsibilities when acting as chaperones including where to sit during the consultation. The practice had a detailed chaperone policy with guidance to follow. All chaperones had received a Disclosure and Barring Service (DBS) check.

The practice used the required codes and flagging system on their electronic case management system to ensure that children and young people who were identified as at risk, including those who were looked after or on child protection plans, were easily identifiable. The practice did not have a central register of those at risk but relied on searches of the record system to identify those patients. For example, vulnerable children and adults that were frequent hospital emergency department attenders. The safeguarding lead was aware of vulnerable children and adults and demonstrated good liaison with local social

services which included a weekly meeting where health visitors and social workers who attended the practice, attending child protection hearings in person or providing a report if unable to attend.

Medicines management

We checked medicines stored in the treatment rooms and within the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures and temperatures were recorded. This also described the action to take in the event of a potential failure. An incident occurred where fridge temperature of one of the practice's vaccine fridges rose to 19 degrees. The vaccines were moved to a new fridge. Further temperature checks were put in place to monitor the temperature of all fridges at the practice.

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. The practice did not hold a stock list for medicines held on the premises but we were informed by staff that this was being developed and we saw evidence of this.

Vaccines were administered by the practice nurse in line with legal requirements and national guidance. We saw evidence that the practice nurse had received the appropriate training to administer vaccines Patients on high risk medications were asked to come to the practice for periodic reviews.

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. Prescription pad numbers were recorded before placing in printers 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 that cleaning records were kept. Patients told us they always found the practice clean and had no concerns about cleanliness. An external cleaning company was employed by the building management and we viewed the cleaning log. Any concerns regarding cleaning were raised directly with the company by the practice manager. The practice manager and the buildings manager undertook a monthly joint spot check and reported any adverse findings to the cleaning company.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and also received annual updates. We saw evidence that an infection control audit had been carried out by the practice in 2014 and that improvements identified for action had been completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. The policy included spillage management, specimen handling and routine equipment decontamination. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed legionella testing was undertaken in September 2014.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that 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 (February 2015). A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example baby scales, diagnostic set, digital blood pressure monitors, spirometers, thermometers, ultrasound and vaccine fridges. Calibration last took place in February 2015.

Staffing and recruitment

Good

Are services safe?

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 was on duty. For example an extra administrative member of staff was on duty on a Wednesday afternoon when the practice was closed to help with any administration work back log. 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 in their contracts. The practice manager maintained a staffing rota system to ensure enough staff was present to cover the practice and to plan for any shortage of staff through sickness, external training or annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

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

Risks that occurred within the practice were discussed within clinical team meetings where an action plan would be established. The plan would then be disseminated to the remainder of the staff team through the practice meeting.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. For example staff gave examples of where there was suspected cases of tuberculosis and how they identified patients that may have the condition. Examples were also given of how patients that were experiencing a mental health crisis were reviewed by the GP and referred to the local mental health team for an urgent mental health review. Staff told us they ensured patients with a long term condition were referred to secondary care if it was noticed through their health review that their condition was deteriorating. We viewed minutes of meetings between the practice and the district nurse team that discussed the ongoing care of patients with a long term condition and those on the practice vulnerable patients register.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a life threatening allergic reaction that can develop rapidly) and hypoglycaemia (low blood sugar level). Processes were in place to ensure that 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 a contract with an oxygen supply company who automatically came to replace oxygen prior to expiry.

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

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. However, we did not find evidence from the minutes of both clinical and practice meetings where new guidelines were discussed. We found, from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

National data showed that the practice had slightly lower referral rates to secondary and other community care services for all conditions than the national average. All GPs we spoke with used national standards for the referral of suspected cancers and mental health conditions. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

To ensure that patients who may be at a higher risk and needed a more detailed needs assessment were identified, a risk stratification tool was used. The tool identified the top 2% of a particular group, for example patients with a high attendance at accident and emergency (including older patients), long term conditions and those patients with mental health concerns. Best practice guidance would then be used to discuss these issues with patients and provide the most up to date care. All unplanned admissions to hospital were reviewed in clinical meetings and we were shown copies of the minutes of the meetings where individual patients were discussed. We viewed care plans for those patients identified and saw how a plan was put in place with the practice to effectively manage their health concerns which included health checks regular reviews. Patients were referred to local services including the community mental health team for further testing and diagnosis. A structured annual medication review was in place for all patients that received more than four medicines and were over the age of 75.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for conducting clinical audits. The practice showed us four clinical audits that had been carried out within the last 12 months. For example, an audit was carried out into patients taking simvastatin (used for lowering cholesterol) with amlodipine (used for widening blood vessels) or diltiazem (used to treat high blood pressure) following an alert from the Medicines and Healthcare Regulatory authority (MHRA). The results of the audit were discussed within practice meetings. Fourteen patients were highlighted and three patients were contacted to have their medicines reviewed. The results of the audit were discussed in clinical meetings. We were presented with no evidence of a completed audit cycle where an audit had been repeated to assess any change in practice.

The GPs told us clinical audits were often linked to medicines management information or safety alerts. We found no evidence that audits were undertaken as a result of information from the quality and outcomes framework (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local Clinical Commissioning Group (CCG) as a whole against the national average. The latest

Requires improvement

Are services effective?

(for example, treatment is effective)

available QOF data (2013/2014) showed that overall the practice is performing below the CCG average (94%) and the national average (93.5%) achieving 80.2%. This was a general figure which included all areas that QOF covered (clinical care, how well the practice was organised, patient viewed, amount of extra services offered by the practice). The practice was aware of the low figure which the practice attributed to a computer coding issue on the clinical system. The practice had achieved 91% for the current year. The practice used this information to ensure that they were on target to deliver a good service and to discuss, in both clinical and practice meetings, how service could be improved.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 77% of patients over 65 years of age had received a flu vaccination. The practice was not an outlier for any QOF (or other national) clinical targets.

The clinical team was making use of Clinical Commissioning Group (CCG) benchmarking against other practices which included reviewing patient attendance at accident and emergency (A&E). Patients were contacted by the practice if they attended A&E frequently and reminded them of the services provided at the practice. Clinical meetings were used to discuss and reflect on how the systems at the practice could be improved to achieve outcomes for patients.

Staff checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that patients had received appointments for all routine health checks for long term conditions such as diabetes and the latest prescribing guidance was being used.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff was up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors who all concentrated on general medicine. All GPs were up to date with their yearly continuing professional development requirements. Two GPs had been revalidated in early 2015 and the rest were to be revalidated by the end of 2015. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one member of the nursing staff was keen to enhance their skills and attended courses in regard to vitamin B. New members of staff received a mentor to work alongside during their three month probationary period.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties (For example, on administration of vaccines and cervical cytology). Those with extended roles for example undertaking asthma reviews and the monitoring of diabetes and chronic obstructive pulmonary disease (COPD) were also able to demonstrate that they had appropriate training to fulfil these roles.

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

Working with colleagues and other services

The practice engaged with other health services to ensure a multi-disciplinary approach to the care and treatment of those with complex care issues.

We were informed that the practice had good working relationships with the health visiting team who were based within the building, the palliative care team and local mental health teams.

Blood tests, X ray results, hospital letters, information from out of hour's providers and the 111 service were received by the practice electronically, reviewed by the administration staff and passed to the GP or nurse to take the appropriate action within 48 hours. All staff understood their role and felt that the system in place worked well.

The practice held monthly multidisciplinary meetings to discuss the needs of complex patients, for example those with long term conditions and children on the at risk register. The meetings were attended by the health visitors, community matrons, district nurses and social workers as necessary. Decisions about care were documented in a

Requires improvement

Are services effective?

(for example, treatment is effective)

record card accessible to all members of staff at the surgery to enable continuity of care. The practice also held a quarterly palliative care meeting attended by the local multidisciplinary care team including, practice GPs, nurses and the palliative care nurse. We reviewed the minutes for the last three meetings which provided a patient update and the action that was to be taken. We were told that further meetings would be called in the interim period if the need arose.

Information sharing

The practice used several electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made 80% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

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 this task using the electronic patient record system, and highlighted the importance of this communication with A&E.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

The practice used a system of passing a request to the on call GP for approval before faxing to the hospital. Codes were used within the electronic system to record this and monitor the activity.

Consent to care and treatment

Staff at the practice had received training in the Mental Capacity Act 2005 and the Children's and Families Act 2014. The clinical staff we spoke with was aware of the key parts of the legislation and was able to demonstrate how it was implemented in practice. For example, staff spoke of the need to ensure that a capacity analysis was undertaken and appropriate consent for treatment was obtained from a patient with dementia. We were shown evidence of care plans which required consent and found that appropriate consent had been received.

All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have legal capacity to consent to medical examination and treatment). We were provided with the practice policy for determining the capacity of patients under 16 to give consent and the procedure for the practice to follow.

Health promotion and prevention

All new patients were offered a consultation with the practice nurse to discuss the patient's lifestyle and to provide information to help improve their lifestyle. This included healthy eating and exercise leaflets and smoking cessation advice. Chlamydia testing and advice was also offered as part of the initial patient consultation for those patients within the age range for this testing. Sexual health advice was offered to young people and those that may be vulnerable. Patients were signposted to other health organisations that could be of service if an issue was identified. The practice also offered a full children's immunisation programme. For example, the latest data available showed that the practice had achieved a vaccination rate of 96.2% for the MMR. No comparative data was available from the Clinical Commissioning Group (CCG). The practice telephoned patients who did not attend for vaccinations as a reminder and to encourage attendance at one of the two clinics held each week for the provision of childhood immunisations. The practice had a childhood immunisations lead to ensure all children were followed up.

The practice shared the care of mothers and children with the community midwives team and the practice nurse to provide antenatal care and support to new parents The practice provided weekly GP led clinics for the provision of the six week check. The practice worked in support of school nurses. Support for the families of premature babies was also given. The practice also operated a register of children at risk or in social services care and GP's attended joint meetings to discuss care. The GP also provided a report for the transition of young people in social services care to adult services. Appointments were available outside school times.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice offered annual health checks and advice to all patients with specific checks for those placed on the long term conditions register which included structured annual reviews, diabetes checks and blood pressure monitoring. Chronic obstructive pulmonary disease (COPD) checks were also carried out and included spirometry checks (measuring lung function). The practice had undertaken annual reviews for 78% of patients on the practice COPD register and 93% of patients on the register had care plans. Sixty percent of patients on the learning disability register had received a health check. The reviews included a medicines check to ensure medicines were still relevant to the condition. The practice ran a nurse led diabetic clinic as diabetes was identified as a local health concern. Quarterly multidisciplinary meetings are held with other health professionals to discuss, monitor and review vulnerable and high risk patients. We were provided with evidence of the minutes of these meetings.

Smoking status was added to patient records and smoking cessation classes were run on an ad hoc basis. The practice was unable to provide data regarding smoking cessation quit rates. The practice proactively monitored patients who may be at risk of developing a long term illness through the practice computer system. These patients were called in on an annual basis for a health check to monitor any developments.

Patients over the age of 75 had a named GP which was recorded within the notes. Searches of the computer record system are undertaken to identify new patients over the age of 75. Reviews were carried out by the nursing team and any experiencing difficulties were either referred to the GP or to an external organisation.

The practice held a register of patients with poor mental health of which, at the time of the inspection, 86% had an agreed care plan. The practice was in the process of ensuring those on the register without a care plan received one. The practice provided annual physical health checks to patients on the register along with regular mental health reviews. The practice worked with a dementia advisor in the advanced care planning for patients with dementia and attended multidisciplinary care reviews to discuss these cases. Each patient on the older persons register had a named GP contact. The practice also attended meetings with the local mental health teams to discuss the case management of patients on the mental health register where the GPs provided regular health reports for the meetings. The practice had the service of an in house consultant psychiatrist who met with the GPs to discuss those on the mental health register and other vulnerable patients known to the practice. A mental health care worker and clinical psychologist met with patients on a weekly basis at the practice to provide a comfortable service for patients in familiar surroundings. The practice referred patients to the local memory service for assessment.

Flu vaccinations were offered to all patients with 75% of over 65s and 55% of patients on the at risk register receiving the vaccination.

The practice had a 78% uptake for cervical screening which was higher than the latest CCG average of 73.4% (2011/2012). The practice offered a Saturday morning nurse clinic which offered this service.

Health advice leaflets were available within the reception area or direct from the nurse. However leaflets were only available in English. Patients were signposted to other health and voluntary organisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and annual patient survey undertaken by the practice's Patient Participation Group (PPG). The evidence from these sources showed patients were positive about the service they received, that they were listened to by staff and treated with respect. Data from the national GP patient survey (406 surveys were sent out and 119 surveys were returned) showed that 83% of patients said the last GP they saw or spoke to was good at giving them enough time, which was above the Clinical Commissioning Group (CCG) average of 81%. The survey also showed that 96% said that they had confidence and trust in the last nurse that they spoke with, which was above the CCG average of 95%. In the latest PPG survey, 81% said that they were satisfied with the overall outcome the last time they visited the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received five completed cards and the majority were positive about the service experienced. Patients commented that staff were very efficient and involved them in the planning of their treatment. They also told us that the environment was clean and safe. However concern was raised by patients regarding the difficulty in obtaining an appointment.

We also spoke with five patients on the day of inspection, which were happy with the service provided.

Staff told us that all consultations were carried out in the privacy of the consulting room. Disposable curtains were provided in consulting rooms. We noted that the doors to the consulting rooms were closed during a consultation to increase confidentiality. The practice provided a chaperone for any patient that made a request for one. Information on the chaperone service was on display in the reception area.

We noted that there was a small distance between the waiting area and the reception desk to ensure patients were not overheard at the desk by those waiting for an appointment. A meeting room across the corridor from the reception desk was a designated area for any patient that wished to talk to a member of staff in private before their consultation.

Staff told us that the practice had a culture of ensuring that patients were treated equally. For example, patients experiencing poor mental health or in vulnerable circumstances were able to access the service without fear of prejudice, and staff treated them equally.

Care planning and involvement in decisions about care and treatment

Patient survey information that we viewed showed patients responded positively to questions about their involvement in the planning of their care. For example, the national GP patient survey showed that 80% of patients said that the GP was good at involving them in their care, and 76% said that the GP was good at explaining test results and treatments However these scores were both below the Clinical Commissioning Group (CCG) average.

Patients we spoke with on the day had no concerns over involvement in their treatment. All patients said that they were fully involved in the decision making process and that all the options for treatment were explained to them. They also told us they felt listened to and supported by staff to make an informed decision about the choice of treatment they wished to receive without being rushed.

Staff told us that translation services were available for patients who did not have English as their first language. Patients were asked by the receptionist if they required a translator and the service was also publicised in reception.

Patient/carer support to cope emotionally with care and treatment

The survey information we viewed showed that people were positive about the emotional support provided by the practice. People told us that when they needed emotional support the GP would offer support through providing an appropriate referral to another service or by providing information of how they could access relevant support groups and counselling services. Patients were contacted by the GP following discharge from hospital. Local voluntary and patient support groups were publicised in reception.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice engaged regularly with the clinical commissioning group (CCG) and within their own locality group to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery. For example we found evidence of a discussion on the 111 service and how they could improve the urgent care services within the area. The practice worked with Public Health England to provide services to respond to these needs. A public health monitoring system was used to assess the effectiveness of the services. No effectiveness data was available at the time of inspection.

The practice had also implemented suggestions for improvements following patient participation group (PPG) feedback. This included the implementation of a new telephone system which provided a call management system to enable auditing of the telephone system to identify any issues faced by patients when they call to book an appointment. Online booking was also to be made available following feedback from the PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the provision of an interpreting service for use within appointments for those patients who did not speak English. The practice had access to face to face, online and telephone interpreting services (including British Sign Language) that could be pre booked for appointments if patients requested to use the service.

The premises and services had been adapted to meet the needs of patient with disabilities. All consultation rooms were on ground level and wider doorways were in place to accommodate wheelchairs. There was step free access throughout the building. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open each week day between 9am and 6.30pm except for Wednesday where the practice was open between 9am and 1pm. Appointments were available each morning between 9am and 1pm, and each afternoon except Wednesday between 3pm and 6.30pm. The practice provided an extended hour's clinic on a Thursday between 6.30pm and 8.30pm. Both a GP and a practice nurse were available for the extended hour's clinic. The practice ran a Saturday morning nurse led clinic which offered the cervical smear test service and routine vaccinations and blood tests.

Comprehensive information was available to patients about appointments on the practice website and within the practice 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.

Issues had been raised by patients regarding access to appointments through the telephone system. The practice had recently implemented a new telephone system with the aim to increase access. Data on improvements through this system was not available at the inspection.

Longer appointments were available for patients who needed them and those with long-term conditions or where an interpreter or advocate may be required. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one. Telephone appointments were available each day for patients unable to attend the practice or in need of health advice from a GP. Vulnerable patients were prioritised for a call back from the GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system including posters within the waiting room, complaints leaflet and information in the practice 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 11 complaints received in the last 12 months and found that these were handled appropriately in line with the practice complaints policy.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and found a common theme throughout of being unable to make an appointment at an appropriate time and patients being unhappy with the triage system. Both areas have been addressed by the practice to improve access to the service. The outcome of complaints was shared in both practice meetings and patient participation group meetings to assess whether any changes in process were needed. We reviewed the minutes and found that policies had been changed as a result of the outcome of complaints including the triage policy.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's long term strategy. These values were clearly displayed in the waiting areas. The practice vision and values included providing the best possible quality service for patients, involving patients in decisions regarding care, promote good health and well-being and involve external healthcare professionals when in the best interest of patients.

We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of practice meetings and saw that staff had discussed and agreed that the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at seven of these policies and procedures including medicines management, infection control and referral policy. All the policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding There was a named GP governance lead who took responsibility to ensure all aspects of governance was working appropriately. Governance was discussed within the weekly clinical meeting and we saw evidence of these discussions. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The current QOF data for this practice showed it was performing below national standards. However the practice were aware of this and were working towards improving the data. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had undertaken some clinical audits which it used to monitor quality and systems to identify where action should be taken. However we found no evidence of audits being repeated to check on improvements.

The practice had arrangements for identifying, recording and managing risks. The practice did not have a risk log; however risks were discussed within clinical meetings when they arose. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, a weekly cleaning schedule was put into place for cleaning medical equipment.

Leadership, openness and transparency

We saw that full team meetings and administration specific meetings were held monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

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

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

The practice had gathered feedback from patients through the annual patient surveys, NHS Choices website and through the NHS friends and family process. We looked at the results of the practice's annual patient survey and 66% of patients agreed that their overall experience of making an appointment was either good or very good. Patients we spoke with shared some concern over making an appointment but stated that it was improving. In response to this, the practice implemented a new telephone system and online appointments booking service.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG). The PPG included representatives from all the various population groups; however the group was not well represented by patients who worked, which was an area the PPG were addressing through a recruitment campaign. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. The PPG also discussed the bigger issues surrounding the practice and regularly discussed developments within the local community and the local Clinical Commissioning Group (CCG) and how these impacted on the practice.

The practice had gathered feedback from staff through staff meetings and annual appraisals. Staff told us they felt comfortable giving feedback and discussing any concerns or issues with management. They told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported continued learning and development through training and mentoring. We looked at staff files and found that regular appraisals took place which included a personal development plan. Staff were encouraged to advance themselves through training.

The practice had completed reviews of significant events and other incidents and shared the information and outcomes with staff during practice meetings to ensure the practice improved outcomes for patients. For example, following an incident where the telephone system was out of action, the correct procedure of placing a recorded message directing patients to the practice mobile telephone was discussed to ensure all staff were aware of the procedure to follow.