The Avenue 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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Avenue Surgery on 21 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the six population groups; 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).

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 and were actively encouraged to do so.
- Information about safety was recorded, monitored, appropriately reviewed and addressed. Opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a GP and that urgent appointments were available the same day.
- Leadership roles were clearly defined and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- There were effective systems in place for the controlling the risk of infection. The practice was clean and hygienic.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

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

Summary of findings

meet their needs. Information about how to complain was available and easy to understand and evidence showed 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 being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings to govern its business. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population which represented 4% of the patients on its register. It provided a range of enhanced services, for example, in dementia and end of life care. The practice offered a full range of immunisations to older people in line with national guidance. Patients over the age of 75 had a named GP. Those identified as at risk of hospital admission had care plans. The practice was responsive to the needs of older people, and offered home visits where required. The practice had access to rapid response teams in the community and worked with multi-disciplinary teams to provide co-ordinated care to older people.

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 worked alongside the GPs to deliver care to people in this population group. The practice had a robust recall system for all people on its register with long term conditions. People with long term conditions had an annual review to check that their health and medication needs were being met. The practice also had a GP who specialised in the management of diabetes who saw patients with more complex symptoms of diabetes twice a year. The practice also had access to a 'virtual' diabetic clinic run by a hospital consultant with a community diabetes specialist nurse.

Families, children and young people

Good

The practice had a high proportion of families, children and young people on its register with 23% of its practice population aged under 16 and 50% under 30. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The practice worked closely with the local health visiting service. All staff had up to date training in safeguarding children and knew how to spot the signs of abuse and what their responsibilities were in relation to this. The practice offered same day appointments to children and young people and saw multiple family members during one appointment if required. The practice provided shared antenatal care with the midwives and had a dedicated midwife for teenage pregnant mothers. The practice

Summary of findings

provided weekly maternal post-natal clinics which enabled mothers to be seen on their own as well as the 6 week baby check. It provided a comprehensive range of contraceptive services including fitting and removal of implants and intrauterine contraceptive devices (IUCDs). The practice had been proactive in improving its cervical cytology rates. It provided a weekly drop in sexual health clinic for patients under 25, who may or may not be registered with the practice.

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 by the practice. A significant proportion of its patients were students. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. It provided extended opening hours two evenings a week and on alternate Saturday mornings. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group which included NHS health checks and smoking cessation.

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 had identified patients living in vulnerable circumstances which included homeless people, travellers, substance misusers and those with a learning disability. It had carried out annual health checks for people with a learning disability. There was a dedicated practice in Brighton for homeless people however the practice still saw homeless patients if required and saw travellers on a temporary patient basis. The practice participated in a city-wide programme for methadone prescribing in stable patients with the support of the substance misuse service. This offered patients prescriptions along with health checks, screening and immunisation against blood borne viruses.

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.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). It offered annual reviews for patients with dementia or those on the serious mental illness register. Dementia screening was offered opportunistically. Mental health emergencies were referred to psychiatric liaison service situated at the local accident and emergency department. The GPs were also able to refer to an urgent mental health response service which saw patients on the same day. The local primary care mental health service regularly saw patients on the practice premises.

Summary of findings

What people who use the service say

We reviewed 47 comment cards where patients and members of the public shared their views and experiences of the service. We also spoke to three patients on the day of the inspection. The feedback we received was consistently and strongly positive. Patients told us that they received an excellent service. They told us that the doctors and nurses listened to them and that all staff were friendly caring and polite. They said they thought the practice was always clean and tidy.

We reviewed the most recent data available for the practice on patient satisfaction. Results of the 2014 national GP survey showed that patients rated the practice higher than others for almost all aspects of care. For example, 92% of practice respondents described the overall experience of the practice as good or very good.

The proportion of practice respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern was 94%.

The practice had undertaken its own survey of patient views during 2014/15 in conjunction with its patient participation group (PPG) which focused on the on-line services and the appointment system. The results showed a significant improvement in satisfaction since the previous year's survey which focused on the same themes. For example, in the 2014/15 survey results 95% of respondents were very satisfied or satisfied that they could now pre-book an appointment with a GP up to six weeks in advance compared to 77% in 2013/14.

The Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to The Avenue Surgery

The practice is situated in the Moulsecoomb area of Brighton and provides general medical services to approximately 6,800 patients. There are three GPs, two male and one female. The practice also employs two practice nurses and one health care assistant. Opening hours are 8.30am to 12pm and 3pm to 6.30pm Monday to Friday with extended hours in operation on Mondays and Tuesdays from 6.30pm to 7.30pm and alternate Saturdays from 8.00am until 11.00am. The practice is closed Monday to Friday between 12.00pm and 3.00 pm. During this time the practice has a GP on duty who can be contacted via the out of hours service which is detailed on the practice's answer phone message. The practice provides a wide range of services to patients, including minor surgery, asthma and diabetes clinics, cervical screening, contraception and sexual health clinics, childhood immunisations, minor surgery, smoking cessation and ante and post natal care. It provides a young person's sexual health drop in clinic for patients aged under 25. Patients don't have to be registered with the practice to attend.

The practice has a higher than average percentage of its population aged between 5 and 14 years of age and under the age of 18. It also has a higher than average percentage population with income deprivation affecting children and older people. The practice has 14.2% of its patients over 18 years in full time education compared to the local clinical commissioning group average of 4.3%. It has less than average percentage of its population aged over 65, 75 and 85.

The practice has opted out of providing Out of Hours services to their own patients. Patients were able to access Out of Hours services through NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including the Brighton and Hove Clinical Commissioning Group (CCG), NHS England and Healthwatch to share what they knew.

During our visit we spoke with a range of staff including, the GPs, the practice manager, the practice nurses, administrative staff and receptionists. We examined practice management policies and procedures. We spoke with representatives from the practices patient

Detailed findings

participation group (PPG) and spoke with three patients. We also reviewed 47 comment cards where patients and members of the public shared their views and experiences of the service.

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)

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

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

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 year and we were able to review these. As a small practice staff were able to discuss significant events as they arose. Significant events were discussed at staff meetings and a dedicated meeting was held annually 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, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, one of the vaccine refrigerators had been identified as being outside the correct temperature range. As a result the refrigerators contents were isolated in alternative vaccine fridge pending investigation. There was evidence that staff were reminded of the processes for cold chain breaches and to report any untoward noises from the refrigerators to the practice manager or manufacturer.

National patient safety alerts were disseminated by email to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were emailed appropriately 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 to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP and a practice nurse as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with 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 to make staff aware of any relevant issues when patients attended appointments; for example children on child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including the health care assistant, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

There was evidence that the practice undertook regular reviews of prescribing data in conjunction with the clinical commissioning group (CCG) which set annual prescribing targets as part of an incentive scheme. For example, patterns of antibiotic, and sedatives prescribing within the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an audit of infection control during the last year and that an action plan was in place to address any improvements identified. Minutes of practice meetings showed that infection control was a regular agenda item.

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. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. 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 arrangements in place 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 the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

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

Staffing and recruitment

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

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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.

Good

Are services 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 regular checks of the building, the environment, the workplace, fire safety. Identified risks were recorded and each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks identified included lone working, legionella, moving and handling, slips and trips, dealing with hazardous substances and the security of the building. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

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 in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure and adverse weather. Relevant contact details for staff to refer to. For example, contact details of the energy supplier, plumbers and electricians.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. As a small practice the GPs met twice a day to discuss cases and share knowledge including new guidelines. There was evidence that actions were taken to ensure that patients received the care and support they needed to achieve the best outcome for them.

The GPs told us they led in specialist clinical areas such as diabetes, palliative care, asthma and minor surgery. The practice nurses also took the lead for specific areas including sexual health and supported the doctors with their work in chronic disease management. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice undertook regular reviews to ensure that patients were receiving the best care and treatment. We were shown a review the practice had undertaken into its high prescribing rated for antibiotics. As a result of this the practice had implemented a strategy for reducing antibiotic prescribing which included the production of patient information, delaying prescriptions for antibiotics where clinically appropriate.

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

The practice showed us 19 clinical audits that had been undertaken in the last year. Most of these were completed audits or had identified dates for re-audit. For completed audits the practice was able to demonstrate the changes resulting since the initial audit. For example, the practice undertook an audit of the acute and repeat prescribing of sedatives with the aim to reduce repeat prescribing. After an initial re-audit the practice was able to demonstrate a 59% decrease in number of patients receiving acute or repeat prescriptions for a particular sedative. A second re-audit showed a further 14.5% reduction in prescribing.

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

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice scored well against most of the QOF indicators For example, 100% of patients aged 75 or over with a fragility fracture on or after 1 April 2012, were being treated with an appropriate bone-sparing agent. Where it had been identified as an outlier, the practice had implemented plans to improve performance. For example, the percentage of women aged 25 or over and who had not attained the age of 65 whose notes record that a cervical screening test had been performed in the preceding 5 years was below what was expected. As a result the practice revised the letter and leaflet it sent to women inviting them for screening to make it more friendly and reassuring. It arranged additional cervical screening clinics on a Saturday morning to make it more convenient for patients to attend and the female GP offered women opportunistic screening during consultations where appropriate. The practice was able to demonstrate increased cervical screening rates as a result.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had been successfully revalidated. (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, the health care assistant was studying for a degree in health and social care practice at the local university.

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.

Working with colleagues and other services

There was evidence that the practice worked closely with other organisations and health care professionals. We saw that the GPs had regular pro-active multi-disciplinary meetings with representatives from the community nursing team, and adult social care to discuss patients with complex health and social care needs and those who may be at risk of admission to hospital. There were also multidisciplinary meetings which included palliative care nurses to discuss the needs of patients on the "palliative care" register. This was part of the Gold Standards Framework which aimed to ensure that people at the end of their life had a high standard of care.

Information sharing

Roles and responsibilities for dealing with information about patients from other providers were clearly defined within the practice. The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic results for pathology and radiology were communicated directly to the doctor via path links directly into the clinical system. It was the responsibility of each doctor to check and action the results regularly during the working day. 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 as well as paper clinical records for each patient. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. All paper communication in relation to a patient's clinical care was appropriately coded onto the patient's electronic record with a copy filed on their paper notes.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005and their duties in fulfilling it. However, due to the nature of the practice population the GPs said they rarely had to apply it. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained and recorded in the patient notes.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic cervical screening to women between the ages of 25 and 64. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over. The practice provided a smoking cessation clinic and a young person's sexual health clinic for the under 25s. There was a range of patient literature on health promotion and prevention available for patients in the waiting area. The practice website provided patients with health advice and information about healthy lifestyles and common illnesses.

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 a survey of patients undertaken by the practice's patient participation group (PPG) in 2014 which focused on the practice's appointment system and on-line services. The evidence from the national survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 92% of practice respondents rated it as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 94 % of practice respondents saying the GP was good or very good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 47 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were friendly, helpful and caring. They said staff treated them with dignity and respect.

Care planning and involvement in decisions about care and treatment

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that all new staff had signed a confidentiality agreement as part of their terms and conditions of employment. Practice staff managed sensitive telephone calls away from the main reception desk.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good or very good at involving them in decisions about their care and 86% felt that the nurse good or very good at involving them in decisions about their care.

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

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, data from the national survey showed that 94% of practice respondents saying the GP was good or very good at treating them with care and concern and 92% saying the nurse was good or very good at treating them with care and concern. The patients we spoke with also told us that the staff were caring and supportive.

Notices in the patient waiting room and information on the practice's website also told patients how to access a number of support groups and organisations including carers support. The practice actively tried to identify and register carers so that it could signpost them to the various avenues of support available to them. The practice regularly referred carers to the local carers support organisation.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the characteristics of its patient population and was responsive to their needs. There was evidence that the practice engaged regularly with the clinical commissioning group and other practices to discuss local needs and service improvements that needed to be prioritised, for example the development of pro-active care across the city.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, improved facilities in the waiting room including provision of appropriate reading material for male patients to complement improved female and children's reading material. It had also provided more information for patients about the on-line appointment system, the availability of appointments up to 6 weeks in advance and extended hours. We noted this information was available on the practice website, patient information TV screen, posters in the waiting room and in the practice leaflet.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example translation services were available for patients whose first language was not English. The practice website had a translate page which enabled the information provided to be translated in to 90 different languages. We saw that administrative and reception staff had undertaken training on equality and diversity.

The premises and services had been adapted to meet the needs of patients with disabilities. All of the services for patients were situated on the group floor. The doors were wide enough for wheelchair access. 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.

Appointments could be made to see a GP between 8.30am to 12pm and 3pm to 6.30pm Monday to Friday. The practice provided extended hours on Mondays and Tuesdays from 6.30pm to 7.30pm and alternate Saturdays from 8.00am until 11.00am. The practice was closed Monday to Friday between 12.00pm and 3.00 pm. During this time the practice had a GP on duty who could be contacted via the out of hour's service. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. Longer appointments were also available for patients who needed them and the GPs often saw multiple family members in one consultation.

Patients were generally satisfied with the appointments system. Many commented that there had been a significant improvement in getting an appointment over the last year. 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. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. The practice's extended opening hours on Mondays and Tuesday evenings and alternate Saturday mornings was particularly useful to patients with work commitments.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the practice leaflet and on the website.

We looked at six complaints received in the last 12 months and found they were handled satisfactorily and dealt with in a timely way. There was evidence that the practice reviewed complaints regularly to detect themes or trends and that lessons learned from individual complaints were shared and acted on.

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. Its aims and objectives were clearly set out in its statement of purpose which was available to patients on the practice's website. All of the staff members we spoke with shared the same commitment to providing high quality care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically in a shared computer folder. We looked at three policies and saw that they had been reviewed annually and were up to date. We saw staff had completed a cover sheet to confirm that they had read policies and procedures that were important and relevant to their area of work.

Leadership roles were clearly defined with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP lead for safeguarding. The staff members we spoke with 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 QOF data for this practice showed it was performing in line with most of the national standards. Where it had been identified as an outlier there was a clear strategy and action plan for improving performance. For example cervical screening. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the prescribing of sedative medication.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues which included lone working, legionella, moving and handling, slips and trips, dealing with hazardous substances and the security of the building. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example a workplace risk assessment for a pregnant staff member.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least every six weeks. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff, for example flexible working, maternity rights, time off, sick pay and compassionate leave. The policies were included in the staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

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

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

The practice had gathered feedback from patients through its patient participation group, complaints, patient surveys and the Friends and Family test. We looked at the results of the annual patient survey which showed that a number of men had commented on the lack of suitable reading material for male patients and as they represented 50% of the patient population the practice recognised this needed to be addressed. We saw as a result of this the practice had had reading material suitable for men in the waiting area.

The practice had an active patient participation group (PPG). The practice had been active in trying to make the group representative of the population group it served and were seeking a student representative to join. The PPG had carried out annual surveys and the chair person met regularly with the practice manager. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website and in the waiting area.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training

Are services well-led?

Good

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

and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had regular protected training days which all staff could attend.

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