Keats 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.

Summary of findings

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Summary of findings

Overall summary

Keats Surgery provides primary medical care and a range of services including maternity care, diabetes, and child health and baby immunisations clinics to 4,400 people in the Edmonton area of north London. It is open Mondays 8 am to 9pm and Tuesday to Friday 8am to 6.30pm. Outside of these times, an out of hour's service is available.

Keats Surgery staff were a small and close-knit unit. Patients were happy with the service, found access to appointments was good, and staff were friendly and helpful. The surgery worked well with other services. There was good access to the practice for older people with mobility difficulties and staff took time with people when needed to discuss their care and treatment. A limited number of specialist clinics were provided by the practice for those with long term conditions. The appointments system was continually under review and changes had been implemented to improve the service for working people and those recently retired. Staff took time to listen to patients such as those with learning disabilities, and understood their needs.

However there was a lack of monitoring systems and clinical and staff meetings which meant that there were shortfalls in the management of the surgery and staff.

Staff had not always undergone appropriate recruitment checks and did not always have appraisals. There were no fire safety procedures or checks so staff may not be able to respond appropriately in the event of a fire emergency.

We carried out an announced inspection on 3 June 2014. The inspection took place over one day and the inspection team comprised a lead inspector, a GP advisor and a practice management specialist. Before the inspection we talked to a range of health and social care professionals in the community who dealt with patients from Keats Surgery. These included pharmacists, care home manager and palliative care nurse. We talked to four patients. On the day of the inspection we observed staff talking to patients and spoke to the practice manager, two doctors including the clinical lead, practice nurse and two receptionists. We reviewed practice management and staff files, and comment cards which patients had posted on the reception desk.

The regulated activities we inspected were diagnostic and screening procedures, family planning, surgical procedures, treatment of disease and disorder or injury and maternity and midwifery services.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were safe and effective arrangements in place for reporting safety incidents. Feedback on incidents and errors was communicated to staff individually or in a group but not in a systematic way. Staff were able to describe the different forms of abuse and had reported safeguarding concerns appropriately. However the practice nurse did not have up to date child protection training.

Referrals of patients were made in a timely manner and systems were in place to invite patients to attend the surgery when there were significant results. Medicines were stored correctly to preserve their properties and emergency medical equipment was available and regularly checked.

Fire safety drills and checks of the alarm system were not carried out and staff had not been recently trained in fire safety, which meant that they may not be able to respond appropriately in the event of a fire.

Effective systems were not in place to reduce the risk and spread of infection as issues identified in an audit in 2013 had not all been actioned. For example, regular hygiene and infection control checks and review had not been implemented.

Are services effective?

Keats Surgery ran audits to comply with QOF (Quality and Outcome Framework) targets and doctors undertook audits as part of their yearly appraisals.

There were no formal clinical team meetings and practice team meetings had lapsed. The last one was in 2013. Staff training records showed that two out of four staff files did not contain evidence that staff had undergone appraisals. There were no formal supervision meetings although staff told us it was a small team and they worked well together and shared information.

Community healthcare staff such as pharmacists, care home manager and palliative care nurse spoke highly of Keats Surgery and said they had good communication with them to liaise and coordinate patient care and treatment. There were no formal multidisciplinary meetings.

A number of clinics were held for health promotion and prevention such as child health screening and smoking cessation.

Summary of findings

Are services caring?

The practice offered a service that was caring and where patients were treated with respect and dignity. During the inspection we observed staff in the reception area speaking to people kindly and trying to accommodate their needs. Patients we spoke to all told us that staff took time to explain their care and treatment. Patients were able to request to be seen by a male or female doctor and a chaperone policy was in place and information regarding it was displayed in treatment rooms and in the reception area.

Patients described being supported to understand their diagnosis and being given options for care and treatment.

Both clinical and non-clinical staff were familiar with the principles of the Mental Capacity Act 2005 and one doctor told us they had carried out assessments for those people who lacked the capacity to consent. Staff were aware of the Gillick competency. This meant that they understood children could give informed consent when appropriate and that a person with parental responsibility gave informed consent otherwise.

Are services responsive to people's needs?

The practice understood the diverse needs of the different populations they served. They trained staff and provided services to accommodate those needs. Patient referrals and results were processed in a timely manner. Clinicians had regular contact and informal meetings with other healthcare professionals such as psychiatrist and palliative care nurse to ensure that appropriate patient information was shared between the services.

The practice had good facilities for people with wheelchairs and pushchairs and interpreting services were available. Patients were happy with the appointments system and said they did not have to wait long to be seen.

The complaints system was advertised to patients but the complaints policy did not set out clear timescales explaining how long a patient would have to wait for a response and investigation of their complaint. Complaints and incidents were not discussed formally although staff told us that the practice manager did give feedback about complaints to them with suggestions for improving the quality of care.

Are services well-led?

The practice had a small, long term and close-knit staff group who felt supported and had their voice heard.

Summary of findings

They described a good atmosphere and staff felt it worked well because of the practice manager.

Senior management recognised that the service needed to improve and develop. They planned to merge with another practice which meant they would be able to provide more services to address the needs of their diverse practice population.

Patient surveys were followed up and steps taken to address issues identified. The main issue in the last few years had been patients wanted to have more appointments during the day and the practice had accommodated this.

Although staff told us they had yearly appraisals to discuss their work and learning and development in the future, we found that some staff records did not contain evidence of this. There were no formal supervision of staff or practice meetings.

The practice did not operate within a framework which allowed them to prioritise and manage risks. Lack of formal arrangements made it difficult to ensure that risks were mitigated before they became issues which directly impacted on quality of care.

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

The surgery was accessible to older people with mobility difficulties and staff took time with patients when needed to discuss their care and treatment. Patients told us they were happy with the service provided and were treated with respect and dignity.

Care home staff told us they had a good relationship with Keats Surgery and doctors attended for home visits when they requested.

The practice was responsive to the needs of older people and used a new local referral pathway for acute assessment of older people to provide prompt and appropriate care for patients at an assessment unit, with the aim of reducing unplanned admissions to hospital.

People with long-term conditions

The practice provided a limited number of specialist clinics for those with long term conditions. The clinical audit was used to identify and call in patients who were due to have checks or tests for conditions such as diabetes but there was no overall strategy to manage long term conditions.

Patients told us they were happy and felt involved with their care and treatment.

Mothers, babies, children and young people

Referrals of mothers and new born babies made from hospitals to the surgery used to occur but the surgery no longer received this information of when mothers had given birth. Patients had to self-refer and this could result in some patients not attending the surgery for post-natal care and advice.

Child immunisation and baby check clinics were held and clinical staff communicated with the health visitor and district nursing teams to provide coordination of care. Staff were fully engaged with safeguarding procedures and flagging those vulnerable children and families on their database so that all staff had access to up to date information.

The working-age population and those recently retired

The practice provided safe, effective, responsive, caring and well-led services to working age people and those recently retired. The appointments system was continually under review and changes had been implemented to improve the service for working people

and those recently retired. The service provided early morning appointments from 8am and late night appointments up to 9pm on a Monday evening which working people and those recently retired found convenient.

People in vulnerable circumstances who may have poor access to primary care

Staff said there were no barriers to accessing care at Keats Surgery for people in vulnerable circumstances. They took time to listen to patients, such as those with learning disabilities, and understood their needs.

Staff were aware of the principles of the Mental Capacity Act 2005 and understood they needed to obtain patient consent. Safeguarding procedures were in place and appropriate referrals for vulnerable adults had been made.

People experiencing poor mental health

Before our inspection we reviewed data which indicated that Keats Surgery had a lower rate than the national average of carrying out health checks for patients with mental illness. Staff told us that all mental health patients were invited for an annual review and health check.

The partner GPs told us they coordinated care for patients with complex needs and referred patients for psychiatric assessments.

Summary of findings

What people who use the service say

We spoke to four patients as part of the inspection and they were complimentary about the staff and said they were treated with respect and confidentiality. They told us they received good care and treatment and the doctors took time to explain things to them. People said they were happy about the appointments system although if they wanted to see a particular doctor they may have to wait. 48 patients completed comment cards which were left in the reception area and only three contained included negative comments. The rest were overwhelmingly positive about reception staff, practice manager and doctors having time to listen and care. They commented about reception staff being compassionate and clinical staff explaining their treatment and the effects of medication.

We also looked at the last two annual patient surveys (2012 and 2013) carried out by an independent research company and found that the practice was rated "among the best" for telephone access in making an appointment. The surgery had improved in the 2013 survey with a higher proportion of patients feeling that doctors involved them in decisions about their treatment.

Areas for improvement

Action the service MUST take to improve

- Patients and other people accessing the building were not protected against the risks associated with unsafe or unsuitable premises because staff did not carry out fire safety checks or drills. The service must train staff and implement fire safety procedures.
- The practice could not demonstrate that all staff underwent appropriate checks such as employment references checks, before they started to work at the surgery. The practice must ensure that staff files contain appropriate recruitment information.
- The provider did not have suitable arrangements in place to ensure that staff received appropriate appraisals. The provider must ensure staff receive annual appraisals.

Action the service COULD take to improve

- Although staff knew about the patient surveys they told us they were not informed of the analysis of the results and the action that the practice was taking to address issues. Staff could be informed of the results of patient surveys.
- There were no regular whole practice meetings or clinical team meetings. The practice was small and information was shared on a daily basis but not in a formal way. Regular focussed meetings would enable staff to keep updated and evaluate and improve the quality of service provided.

Good practice

Our inspection team highlighted the following areas of good practice:

- There was good coordination and standard of care for palliative care patients with referrals to hospice and other services. Patients were regularly visited by their own doctors. This personalised care was reflected in one of the patient comment cards regarding how the surgery and doctors been supportive during difficult times.
- Patients felt the practice responded to their needs in a person-centred way because they operated with a small, friendly team which they liked.

Keats Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector, a GP specialist advisor and a practice management specialist.

Background to Keats Surgery

Keats Surgery is a GP surgery with 2 partner GPs and a practice nurse. It offers a number of services such as family planning and minor surgery. They hold several specialist clinics including smoking cessation and well-woman. The surgery also runs a comprehensive programme of health promotion and education.

The practice provides primary care for over 4,400 patients within the Edmonton area of north London. The practice has a high percentage of over 65 year olds and under 18 year olds living in deprivation compared with the neighbouring practice areas. The population groups the practice served has a high proportion of ethnic minority people.

The main concerns identified prior to the inspection were that there were lower than average number of health checks for patients with poor mental health. Lower than average number of patients were attending smoking cessation, chronic heart disease and diabetes clinics. There were high attendance rates of patients at the hospital accident and emergency department.

Positive aspects were that the practice had good patient satisfaction rates.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before.

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We reviewed the

Detailed findings

comments people had made on the NHS Choices website. We asked the practice to put comment cards in the reception area, where patients and carers/relatives could share their views and experiences of the practice.

We carried out an announced visit on 3 June 2014. During our visit we spoke with a range of staff, including the practice manager, GP lead clinician, GP partner, practice nurse and two reception/administration staff. We spoke to four patients. We looked at the practice's policies, procedures and audits. We reviewed management and staff files. 48 people wrote comments on cards which we reviewed. We spoke to other healthcare professionals in the community such as two pharmacists, palliative care nurse and care home manager.

Are services safe?

Summary of findings

There were safe and effective arrangements in place for reporting safety incidents. Feedback on incidents and errors was communicated to staff individually or in a group but not in a systematic way. Staff were able to describe the different forms of abuse and had reported safeguarding concerns appropriately. However the practice nurse did not have up to date child protection training.

Referrals of patients were made in a timely manner and systems were in place to invite patients to attend the surgery when there were significant results. Medicines were stored correctly to preserve their properties and emergency medical equipment was available and regularly checked.

Fire safety drills and checks of the alarm system were not carried out and staff had not been recently trained in fire safety, which meant that they may not be able to respond appropriately in the event of a fire.

Effective systems were not in place to reduce the risk and spread of infection as issues identified in an audit in 2013 had not all been actioned. For example, regular hygiene and infection control checks and review had not been implemented.

Our findings

Safe Patient Care

There were effective arrangements in place for reporting safety incidents. The practice had a policy on Significant Event Analysis (SEA)s and staff were aware of the policy, which was easily accessible to staff in reception. We reviewed seven SEAs which had been filed. Details that were recorded included the key risks and learning outcomes for staff. Feedback on incidents and errors was communicated verbally to staff individually or in a group but not in a systematic way.

Safeguarding incidents were highlighted on the practice database so that all staff were aware of this whenever they accessed the patient records.

Staff understood the process for reporting SEAs and safeguarding concerns and told us they discussed them with the practice manager.

Learning from Incidents

Staff described learning that took place from incidents. One SEA concerned a patient who had complained about the fact they felt uncomfortable that a member of reception staff had communicated with another patient in their own language and not English. The surgery had a large number of patients from ethnic minority backgrounds and so staff had considered this incident and decided that it was important to speak to patients with a poor understanding of English, in their own language, in order to better explain their care to them. Feedback on incidents was communicated to staff verbally.

Safeguarding

Both partner GPs took lead roles in children and adult safeguarding and were trained to Level 3 which was in line with national safeguarding guidance. However when we looked at the training records for the practice nurse we found they had not undertaken recent safeguarding training and so were not up to date. Other non-clinical staff had received formal safeguarding training at Level 1.

A safeguarding policy was in place and a safeguarding referral pathway on display in the reception area, so that staff would be able to refer incidents appropriately. Staff were able to describe the different forms of abuse and how they would report a concern. Staff knew who the safeguarding lead and deputy leads were for both children and vulnerable adults.

Are services safe?

The clinical lead GP described concerns they had reported. For vulnerable adults, as well as reporting the information to the appropriate local authority contact, they contacted the district nursing team and carers of the patient to discuss care pathways. The GP described a child safeguarding issue which they followed up with a referral to a paediatrician.

Monitoring Safety & Responding to Risk

There was a business continuity plan in place to deal with emergencies which might interrupt the smooth running of the service. The clinical lead told us that they tried to ensure continuity of care by having two long-term locums who covered for them during planned annual leave and some emergency cover.

Referrals of patients to hospitals for further tests were carried out on the day or shortly after by the practice manager or doctor. For urgent referral (two weeks wait), these were done immediately on the day. The majority of results came back to Keats Surgery electronically so that there was less chance for delay and missing information. Results went through to a doctor's electronic mailbox to be reviewed. If they were significant staff called patients immediately and sent a letter if contact could not be made. For routine results, if staff had not been able to contact the patient, a copy of the results stayed in the practice manager's mailbox for one month to remind them to send a letter.

Similar systems were used for annual health checks for patients with diabetes or hypertension where all outstanding tests required for an individual were flagged up on the patient's records held on the Vision database, each time the patient attended for a consultation.

Medicines Management

Medicines (including those used for immunisation) were stored in clean fridges and temperatures were monitored on a daily basis, which was important to ensure that the medicines retained their properties. The practice nurse, who was the infection control lead, regularly checked the fridges. We looked at a number of medicines in the fridge and found they were all within their use by dates and saw that the checklist on the door had been completed. In the event of a fridge breakdown, the surgery had a coolbag to transport their medicines to another surgery and preserve the cool chain. They also had the contact details of a fridge engineer they could call out if necessary.

Cleanliness & Infection Control

The practice appeared clean and tidy throughout. The decoration was clean and there was easy to clean furniture and equipment. All the treatment rooms appeared clean and we saw staff wiping down equipment after seeing patients. There were alcohol hand gel dispensers throughout the premises and guidance on hand-washing techniques displayed at wash hand basins.

Comment cards we reviewed and patients we spoke to were happy with the general cleanliness and décor of the practice.

Staff had carried out infection control training and the practice nurse was the infection control lead. An infection control audit had been carried out by an independent organisation. That audit had identified a number of shortfalls such as staff not having infection prevention and control training and no cleaning schedules. However, the practice manager told us that not all issues had been actioned even though the audit had been carried out in March 2013. There had been no further audits or reviews since that time. The nurse told us that although they carried out infection control checks in their own room they only carried out checks in other parts of the practice when they had time.

Staffing & Recruitment

All but one of the reception/administration staff had worked at Keats surgery for over 20 years and staff we spoke to described it as a small and close-knit team. Staff felt supported and described the practice manager as approachable and helpful. They covered for one another during busy periods.

We checked staff files of those clinical staff that had been most recently employed by the surgery and could not find evidence that all appropriate checks were undertaken before staff began work. Files contained criminal records checks but there was no evidence of checks on identity or right to work in the UK. Some files had no written employment references or evidence to show they had been sought and an account of verbal references made. We discussed this with the practice manager who said they did have verbal references but sometimes it was difficult to obtain written ones for staff.

Dealing with Emergencies

We were told that all staff underwent annual mandatory training in basic life support (BLS). We checked staff files

and found that the health care assistant did not have recent training in BLS within the last twelve months although this had been booked for the 9 June 2014. All staff including non-clinical staff were able to describe how they would react in the event of a medical emergency and knew where the emergency medical kit was stored.

Fire safety drills and checks of the alarm system were not carried out and staff had not been trained in fire safety, which meant that they may not be able to respond appropriately in the event of a fire.

Equipment

There was an emergency medication kit and oxygen which was regularly checked by the practice nurse. We saw the oxygen cylinder was within date and in working order. Medicines were all within their use-by dates.

Other equipment in the surgery such as scales and blood pressure machines were serviced and calibrated annually.

Are services effective?

(for example, treatment is effective)

Summary of findings

Keats Surgery ran audits to comply with QOF (Quality and Outcome Framework) targets and doctors undertook audits as part of their yearly appraisals.

There were no formal clinical team meetings and practice team meetings had lapsed. The last one was in 2013. Staff training records showed that two out of four staff files did not contain evidence that staff had undergone appraisals. There were no formal supervision meetings although staff told us it was a small team and they worked well together and shared information.

Community healthcare staff such as pharmacists, care home manager and palliative care nurse spoke highly of Keats Surgery and said they had good communication with them to liaise and coordinate patient care and treatment. There were no formal multidisciplinary meetings.

A number of clinics were held for health promotion and prevention such as child health screening and smoking cessation.

Our findings

Promoting Best Practice

Clinical staff received updates relating to best practice or safety alerts electronically or when attending meetings and training. They had implemented NICE guidance updates on the use of statins. However we were shown infertility guidance they used which was dated 2004 and was out of date.

The computer database flagged up when patients with poor mental health were due to be called in for health and medication reviews. There were on call systems in place for doctors and staff were clear about the system.

Two staff processed repeat prescriptions and monitored patient records for due and overdue prescriptions so that they could send a reminder to patients to collect their prescriptions. This was particularly important for some population groups within the practice who did not always understand the importance of continuing with their medication. Staff opportunistically used the person's prescription to attach a blood form for example, to remind them to have a test.

Patients we spoke to and those who responded on comment cards were happy with their care and treatment.

Management, monitoring and improving outcomes for people

The practice ran audits to comply with QOF (Quality Outcome Framework) targets and doctors undertook audits as part of their appraisal, for instance on chronic obstructive pulmonary disease (COPD). There was no systematic procedure for contacting patients regularly for health reviews but they were called in opportunistically when repeat prescriptions for example were being processed. Prescribing audits on emollients and statins had been completed.

The practice monitored outcomes for patients and attended monthly peer group meetings with neighbouring surgeries and the Clinical Commissioning Group (CCG). They received information at the meetings about issues such as high attendance rates of their patients at hospital accident and emergency departments. Keats surgery had a high attendance rate in 2013 and they took steps to educate patients not to attend unnecessarily. They gave those patients who attended frequently, leaflets with

Are services effective?

(for example, treatment is effective)

information on the out of hour's service and there was information about it on the television screen in the waiting area. By February 2014, this rate had decreased significantly.

Staffing

The practice had two partner GPs, practice manager, one practice nurse, one health care assistant and four reception/administrative staff. Most staff had worked at the surgery for over 10 years and there was low staff turnover. Long term locum doctors were used to cover for sickness and annual leave. There was no supervision of the work of locum GPs as the clinical lead said they were long term locums.

There were no formal clinical team meetings and practice team meetings had lapsed. The last one was in 2013. The practice manager and doctors discussed practice issues on a daily basis and met informally every three months but did not record these meetings or any outcomes from them. The GP partners discussed complex cases and exchanged information on a daily basis. Non-clinical staff felt the practice manager and clinical staff were all approachable and they could discuss matters with them when they needed to.

Both GPs told us their revalidations and appraisals were due later in 2014. Revalidation is the process by which doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. We checked the practice nurse was registered with the Nurse and Midwifery Council (NMC).

We reviewed staff training records and found that some staff were not up to date with mandatory training. The healthcare assistant did not have recent training in basic life support although this had been booked for the 9 June 2014. Staff said they were supported to attend other courses.

We spoke to the nurse who told us they received appropriate and effective professional support from clinicians. The nurse told us they had annual appraisals with the doctor however when we checked training records we found that there was no evidence to demonstrate this. We reviewed three other staff files and could not find details of appraisals in two of them. There were no formal supervision meetings although staff told us it was a small team and they worked well together and exchanged information.

Working with other services

Clinical staff told us they had frequent and good communication with other healthcare providers such as hospices and district nurses. However, there were no formal multidisciplinary meetings. Care for patients was integrated with the out of hours provider Barndoc, and practice staff told us that if they had visited a patient the information came in electronically by 8 am next day so that patient records could be updated.

As part of this inspection we spoke to health and social care professionals in the community such as pharmacists, care home manager and palliative care nurse. The pharmacists told us they had good communication with the surgery and there was no delay in patients receiving their repeat prescriptions. They were able to talk to the GPs easily if they had any queries. One pharmacist told us that if they telephoned the surgery about a patient they took it seriously and responded well. For example, a person had gone to the pharmacist with a severe insect bite reaction and when they spoke to the practice manager, they had immediately arranged for the patient to attend an emergency appointment at Keats Surgery.

The palliative care nurse said they had a good working relationship with the practice and found it easy to telephone them. They said all the staff were helpful and they had recently communicated on several occasions with one of the doctors regarding a palliative care patient. One care home manager said that if they called the surgery and asked for a doctor to attend, the doctor came within a reasonable time. If they contacted the out-of-hours service at the surgery and one of those doctors attended their patient, the information on the patient records appeared to be updated quickly. This meant that there was effective communication about a patient's care across the healthcare services.

Practice staff had undertaken training in Coordinate my Care (CMC) with the aim of ensuring effective communication between services regarding palliative care and end-of–life patients. The purpose was to improve care and decrease admissions to hospital for this group of patients. There had been very regular meetings with the district nurses but a recent change of staff meant there had not been one for some time. However, there was regular meeting and liaison with the health visitor.

Are services effective?

(for example, treatment is effective)

Health Promotion & Prevention

New patients were given an information pack when registering with the surgery and offered a consultation to ascertain details of their past medical and family histories. This included a general health check.

Every year in October the surgery held flu vaccination clinics to offer patients flu injections. For those patients who were housebound flu injections were offered at home.

A number of clinics for health promotion and prevention were held such as health screening and smoking cessation. The nurse worked 3 sessions a week and the healthcare assistant for 1 day so the number of healthcare clinics that were held were limited.

There was a healthcare monitor in the waiting area for patients to use themselves which gave them information to them on their height, weight and body mass index. Information on a range of topics such as sexual health and healthy living was available in the waiting area.

Are services caring?

Summary of findings

The practice offered a service that was caring and where patients were treated with respect and dignity. During the inspection we observed staff in the reception area speaking to people kindly and trying to accommodate their needs. Patients we spoke to all told us that staff took time to explain their care and treatment. Patients were able to request to be seen by a male or female doctor and a chaperone policy was in place and information regarding it was displayed in treatment rooms and in the reception area.

Patients described being supported to understand their diagnosis and being given options for care and treatment.

Both clinical and non-clinical staff were familiar with the principles of the Mental Capacity Act 2005 and one doctor told us they had carried out assessments for those people who lacked the capacity to consent. Staff were aware of the Gillick competency. This meant that they understood children could give informed consent when appropriate and that a person with parental responsibility gave informed consent otherwise.

Our findings

Respect, Dignity, Compassion & Empathy

During the inspection we observed staff in the reception area speaking to patients respectfully and trying to accommodate their needs. There were up to date leaflets and posters with information such as smoking cessation and healthy living. Patients we spoke to all told us that staff treated them with respect and dignity. Comments made on the cards included staff listened and one patient told how reception staff had been particularly helpful in registering a terminally ill relative at the practice.

There was a board in the staff area which identified recently deceased patients. It enabled staff to be more sensitive to recently bereaved relatives. Leaflets on bereavement counselling were on display at reception.

Staff spoke a number of languages and told us they used to use Language Line but now used an interpreting service, which was less convenient because it had to be pre-booked. Staff said that sometimes family members and carers interpreted for patients when necessary. They did not have a hearing loop to assist those people who were hard of hearing, but would offer to take them into a separate room to talk.

Patients were able to request to be seen by a male or female doctor and a chaperone policy was in place and information regarding it was displayed in treatment rooms and in the reception area. A patient could request to have someone else of the same gender with them, present in the room during an intimate examination.

Staff approached people in a person-centred way and they tried to accommodate people's different needs. One member of reception told us that if a homeless person attended they would treat them as a priority.

The practice manager and reception staff described how they maintained patient confidentiality. They had a separate room if patients wanted to talk confidentially to them. Paper records were stored securely and computer records could only be accessed with secure login details which were given to authorised staff members.

Involvement in decisions and consent

Patients described being supported to understand their diagnosis and being given options for care and treatment.

Are services caring?

Staff took all reasonable steps to enable people to make decisions about their own care and treatment wherever possible. They had access to the community psychiatric team and other professionals.

Both clinical and non-clinical staff were familiar with the principles of the Mental Capacity Act 2005 and one doctor told us they had carried out assessments for those people who lacked the capacity to consent. Staff were aware of the Gillick competencies.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice understood the diverse needs of the different populations they served. They trained staff and provided services to accommodate those needs. Patient referrals and results were processed in a timely manner. Clinicians had regular contact and informal meetings with other healthcare professionals such as psychiatrist and palliative care nurse to ensure that appropriate patient information was shared between the services.

The practice had good facilities for people with wheelchairs and pushchairs and interpreting services were available. Patients were happy with the appointments system and said they did not have to wait long to be seen.

The complaints system was advertised to patients but the complaints policy did not set out clear timescales explaining how long a patient would have to wait for a response and investigation of their complaint. Complaints and incidents were not discussed formally although staff told us that the practice manager did give feedback about complaints to them with suggestions for improving the quality of care.

Our findings

Responding to and meeting people's needs

Keats Surgery served a widely diverse patient population. Staff understood and accommodated patients different needs and there were several nurse-led services such as diabetes, asthma and well-person clinics. They carried out blood pressure monitoring and injections. Both the practice nurse and health care assistant worked on a part time basis so the number of clinics offered to patients was limited.

We observed staff speaking to patients kindly and respectfully. Where the practice was unable to meet the needs of the different people it served, there were posters and leaflets in the waiting area such as information on carers and older people with long term conditions. Information was all in English although staff between them spoke a number of different languages including Greek and Tamil.

The practice manager had undertaken specific training in communicating with people with learning disabilities. She said that patients with learning disabilities always attended the surgery with their carers.

Patients we spoke to could choose to be seen by a male or female doctor and a chaperone policy was offered to those who may want a member of the same sex to be present when undergoing an intimate examination.

There were administration systems in place to monitor that referral letters were sent out in a timely manner and patients contacted about significant test results.

Access to the service

The premises met the needs of patients with poor mobility. There was ground floor access to the practice and disabled toilet facilities. Treatment and consulting rooms were on the ground floor. The entrance and reception area were spacious enough to accommodate people with pushchairs and wheelchairs. Two patients in motorised wheelchairs were able to see doctors in the treatment room. Staff we spoke to said they had access to pre-book an interpreter for patients with poor understanding of English.

A clear practice leaflet was available detailing information about the services provided, repeat prescriptions and the complaints system. The practice did not have a website although the practice manager told us that this was in the

Are services responsive to people's needs?

(for example, to feedback?)

process of being set up. Information about Keats surgery on the NHS Choices website was inaccurate and conflicted with information in the leaflet and what staff told us. However, during the inspection this information on the surgery was updated. The surgeries operated from 8am to 9pm on Mondays and 8am to 6.30pm Tuesdays to Fridays. Outside these hours, the service operated an out of hour's service which patients could access by dialling 111.

A number of clinics for health promotion and prevention were held such as health screening and smoking cessation. The nurse worked 3 sessions a week and the healthcare assistant for 1 day so the number of healthcare clinics that were held were limited.

The appointments system was monitored and improved access for patients. There was no telephone triage system but reception staff told us they could speak to one of the doctors and usually fit in a patient to the list on the same day if necessary. Doctors confirmed that they covered the hours in between the morning and afternoon surgeries and saw patients at that time. Emergency appointments were available throughout the day. They also carried out home visits on most days.

People told us and wrote comments indicating they were happy with the appointments system. They could see the doctor on the same day if it was an emergency and two to three days for routine appointments. If they wanted to see a particular doctor they may have to wait up to two weeks. They said they did not have to wait long to be seen after they arrived at the surgery as a few years ago patients were asked not to be late and this meant the surgeries ran more on time.

Concerns & Complaints

The practice did not have a Patient Participation Group (PPG) although staff told us they were trying to set one up. Two patients we spoke to had heard about the efforts to establish a PPG and on the day of the inspection we found a table in the waiting area with information on "Patient Awareness Week" to try to recruit members.

Information on how patients could make a complaint, including appropriate contact details, were on display in the waiting area and contained in the practice leaflet. The practice had a complaints policy but this lacked timescales explaining how long a patient would have to wait for a response and investigation of their complaint. There were no contact details within the policy of how to people could escalate a complaint if they were unsatisfied with the response from the practice. Staff were aware of the complaints policy and said they would refer patients to the practice manager if they wanted to make a complaint. Complaints and incidents were not discussed formally although staff told us that the practice manager did give feedback about complaints to them with suggestions for improving the quality of care.

No complaints had been recorded since 2012. We looked at three from 2012 and found people were sent comprehensive response letters detailing the investigation into their complaint.

Annual patient surveys were carried out by an independent research company and the doctors carried out patient surveys as part of their appraisal. A "tracker" IPad was available at the reception desk so that patients could record their comments electronically. Staff told us there had been poor uptake of this facility by patients and they had not yet analysed the results of this as it had only been available for one month. The practice manager had not responded to comments on NHS choices website as they had not been aware how to access it to do so. They said they would do so in future as they managed to get access rights during the course of our inspection.

Staff were familiar with the whistleblowing policy if they should have any concerns regarding senior staff so that they had information on external organisations they could contact.

Are services well-led?

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

Summary of findings

The practice had a small, long term and close-knit staff group who felt supported and had their voice heard. They described a good atmosphere and staff felt it worked well because of the practice manager.

Senior management recognised that the service needed to improve and develop. They planned to merge with another practice which meant they would be able to provide more services to address the needs of their diverse practice population.

Patient surveys were followed up and steps taken to address issues identified. The main issue in the last few years had been patients wanted to have more appointments during the day and the practice had accommodated this.

Although staff told us they had yearly appraisals to discuss their work and learning and development in the future, we found that some staff records did not contain evidence of this. There were no formal supervision of staff or practice meetings.

The practice did not operate within a framework which allowed them to prioritise and manage risks. Lack of formal arrangements made it difficult to ensure that risks were mitigated before they became issues which directly impacted on quality of care.

Our findings

Leadership & Culture

Senior management recognised that the service needed to improve and develop. They planned to merge with another practice and move to a new purpose-built building which meant they would be able to provide more services to address the needs of their diverse practice population.

The practice had a small, long term and close-knit staff group who felt supported and had their voice heard. They described a good atmosphere and staff felt it worked well because of the practice manager.

Governance Arrangements

When we asked practice staff about governance arrangements they were clear about who was responsible for each area. When asked they knew who the responsible leads were for various areas such as safeguarding and infection control.

The two partner GPs spoke to each other on a daily basis regarding complex cases or to offer a second opinion. They also had informal meetings and discussions with the nurse. Information about SEAs was shared but not in a formal way so that there was no review to ensure that lessons had been learned. There were no formal minutes of clinical meetings and although whole practice meetings used to occur regularly, this had lapsed and they had not taken place in within the last eight months.

Patient Experience & Involvement

The practice had monitored patient comments on the NHS choices websites but not responded as they had not been aware how to access it to do so. They said they would do so in future as they managed to get access rights to the website during the course of our inspection.

The practice did not have a Patient Participation Group (PPG). They described how they were trying to develop one and on the day of the inspection we found a table in the waiting area with information on “Patient Awareness Week” to try to recruit members.

Patient surveys were followed up and steps taken to address issues identified. The main issue in the last few years had been patients wanted to have more appointments during the day and the practice had responded by having the gap between morning and

Are services well-led?

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

afternoon surgeries filled, so that patients could be seen then. There was commitment from senior management staff to improve listening to patients and involving them although this was not always communicated to staff.

Staff engagement & Involvement

The practice management had informal arrangements for engaging with staff which worked well to create a good working atmosphere. Senior management told us they organised a meal at a restaurant, from time to time, for staff to help in building a good working relationship.

Although staff told us they had yearly appraisals to discuss their work and learning and development in the future, we found that some staff records did not contain evidence of this. There were no formal supervision or practice meetings.

Staff were aware of the whistleblowing policy and told us that they felt their line manager and all clinical and non-clinical leads were approachable.

Practice management staff attended locality and peer group meetings which provided opportunities for shared learning.

Learning & Improvement

GPs told us they tried to continuously improve care for their patients. They felt that the service would improve when they merged with the other practice and would enable them to provide a higher quality of service to their patients. The practice manager described their individual targets and other staff told us they attended training and that information was shared and cascaded.

Although staff knew about the patient surveys they told us they were not informed of the analysis of the results and the action that the practice was taking to address issues.

Identification & Management of Risk

Although staff identified and managed risks well with patients on a daily basis the practice did not operate within a framework of which allowed them to prioritise and mitigate risks. Lack of formal arrangements made it difficult to ensure that risks were mitigated before they became issues which directly impacted on quality of care.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The surgery was accessible to older people with mobility difficulties and staff took time with patients when needed to discuss their care and treatment. Patients told us they were happy with the service provided and were treated with respect and dignity.

Care home staff told us they had a good relationship with Keats Surgery and doctors attended for home visits when they requested.

The practice was responsive to the needs of older people and used a new local referral pathway for acute assessment of older people to provide prompt and appropriate care for patients at an assessment unit, with the aim of reducing unplanned admissions to hospital.

Our findings

Patients told us they were happy with the service provided and treated with respect and dignity. They said staff took time with them when needed to discuss their care and treatment. Patients told us they were referred to other services such as physiotherapy and felt that treatment was joined up with other healthcare providers.

Staff we spoke to at a care home told us they had a good relationship with Keats Surgery and doctors attended for home visits when they requested. Flu jab vaccination clinics were held annually and housebound patients were offered this service at home. Clinical staff made appropriate safeguarding referrals of vulnerable older adults.

The practice was using a new local referral pathway for acute assessment of older people to provide prompt and appropriate care for patients at an assessment unit, with the aim of reducing unplanned admissions to hospital. They were also able to telephone and discuss patients with a consultant geriatrician based at the unit.

There was regular contact with the palliative care nurse and district nursing teams which gave clinical staff the opportunity to coordinate and review care and treatment needs for those patients on the palliative care register.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice provided a limited number of specialist clinics for those with long term conditions. The clinical audit was used to identify and call in patients who were due to have checks or tests for conditions such as diabetes but there was no overall strategy to manage long term conditions.

Patients told us they were happy and felt involved with their care and treatment.

Our findings

The practice provided a limited number of specialist clinics for those with long term conditions. The clinical audit was used to identify and call in patients who were due to have checks or tests for conditions such as diabetes. Opportunistic screening was completed during routine consultations.

All repeat prescription were reauthorised by doctors and they used this opportunity to invite patients for review and monitoring of their progress.

There was staff awareness that there was a higher percentage of deprivation in older people in their practice population, which would mean more chronic diseases. Although an audit on cardiopulmonary heart disease had been carried out within the last year, there was no overall strategy to manage long term conditions. The Vision database was used to alert when annual health checks were due and opportunistic screening was completed during routine consultations.

Information on helping patients to manage their conditions was available in the waiting area and staff printed information from their computer system to give them when necessary. Patients were signposted to other support services for example, for patients who had partners with dementia. Patients told us they were happy with their care and treatment and felt staff engaged and involved them.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Referrals of mothers and new born babies made from hospitals to the surgery used to occur but the surgery no longer received this information of when mothers had given birth. Patients had to self-refer and this could result in some patients not attending the surgery for post-natal care and advice.

Child immunisation and baby check clinics were held and clinical staff communicated with the health visitor and district nursing teams to provide coordination of care. Staff were fully engaged with safeguarding procedures and flagging those vulnerable children and families on their database so that all staff had access to up to date information.

Our findings

We were told that in the past the practice had received information from hospitals when mothers and new born babies were discharged. This had lapsed and they no longer received referrals so patients had to self-refer to the practice for post-natal care which may mean that some patients could “slip through the net” and not receive appropriate care. The clinical lead GP told us they had realised this concern with the local Clinical Commissioning Group (CCG).

Child health surveillance clinics were held and babies had their six week check with the nurse or doctor. The GP clinical lead raised a clinical staff communicated with the health visitor and district nursing teams to provide coordination of care.

The child safeguarding lead attended quarterly safeguarding meetings with multidisciplinary teams to share information and improve the safety of vulnerable children. All staff was aware of safeguarding procedures and informed appropriate authorities when necessary. They used the practice database to highlight vulnerable children and their families so that all staff would have access to up to date information.

Staff were aware of the Gillick competency. This meant that they understood some children can give informed consent when appropriate and that a person with parental responsibility gave informed consent otherwise.

There were no formal meetings with health visitors but if necessary staff made contact with each other to provide coordination of care.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice provided safe, effective, responsive, caring and well-led services to working age people and those recently retired. The appointments system was continually under review and changes had been implemented to improve the service for working people and those recently retired. The service provided early morning appointments from 8am and late night appointments up to 9pm on a Monday evening which working people and those recently retired found convenient.

Our findings

The practice responded to the needs of working people by offering early norming appointments from 8am and a late night appointment up to 9pm on a Monday evening. In response to patient feedback they had introduced a "rolling surgery" during the day so that appointments were available during the middle of the day. Patients from this group told us they had no problems in booking appointments and found appointment times convenient. In the last two years patients had been told to attend the surgery at the time of their appointment otherwise they may not be seen. Patients said this had improved the waiting times and they saw the doctor now at or near the time of their given appointment.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Staff said there were no barriers to accessing care at Keats Surgery for people in vulnerable circumstances. They took time to listen to patients, such as those with learning disabilities, and understood their needs.

Staff were aware of the principles of the Mental Capacity Act 2005 and understood they needed to obtain patient consent. Safeguarding procedures were in place and appropriate referrals for vulnerable adults had been made.

Our findings

We spoke to reception staff who said there were no barriers to accessing Keats Surgery for people such as those who were homeless. One staff member told us they would treat urgently any request from a homeless person for treatment and discuss with the manager how to register the patient. They said that patients with learning disabilities generally attended with their carers and the practice manager understood that pictorial information was beneficial when communicating with this group of people.

Staff were aware of the principles of the Mental Capacity Act 2005 and understood they needed to obtain patient consent. They took time to listen to patients such as those with learning disabilities and understood their needs. Safeguarding procedures were in place and appropriate referrals for vulnerable adults had been made.

There were posters and leaflets in the waiting area advising people and their families of services and support for people with learning disabilities.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Before our inspection we reviewed data which indicated that Keats Surgery had a lower rate than the national average of carrying out health checks for patients with mental illness. Staff told us that all mental health patients were invited for an annual review and health check.

The partner GPs told us they coordinated care for patients with complex needs and referred patients for psychiatric assessments.

Our findings

Before our inspection we reviewed data which indicated that Keats Surgery had a lower rate than the national average of carrying out health checks for patients with mental illness. Staff told us that all mental health patients were invited for an annual review and health check. These checks included other screening checks such as monitoring blood pressure.

The partner GPs told us they coordinated care for patients with complex needs and referred patients for psychiatric assessments.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because they did not carry out fire safety checks to ensure adequate maintenance and operation of the premises. Regulation 15(1)(c)(i)

Regulated activity	Regulation
Family planning services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because they did not carry out fire safety checks to ensure adequate maintenance and operation of the premises. Regulation 15(1)(c)(i)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because they did not carry out fire safety checks to ensure adequate maintenance and operation of the premises. Regulation 15(1)(c)(i)

Regulated activity	Regulation
Surgical procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.

This section is primarily information for the provider

Compliance actions

People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because they did not carry out fire safety checks to ensure adequate maintenance and operation of the premises. Regulation 15(1)(c)(i)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because they did not carry out fire safety checks to ensure adequate maintenance and operation of the premises. Regulation 15(1)(c)(i)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider did not ensure that information specified in Schedule 3 showing satisfactory evidence of conduct in previous employment was available in staff files. Regulation 21(b)

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This section is primarily information for the provider

Compliance actions

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Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers The provider did not have suitable arrangements in place to ensure that staff received appropriate appraisals and the practice nurse did not have the required level of child protection training. Regulation 23(1)(a)

Regulated activity	Regulation
Family planning services	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers

This section is primarily information for the provider

Compliance actions

	The provider did not have suitable arrangements in place to ensure that staff received appropriate appraisals and the practice nurse did not have the required level of child protection training. Regulation 23(1)(a)

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