

# Warrior Square Surgery

## Quality Report

7th Floor,  
Cavendish House,  
Hastings,  
East Sussex  
TN34 3AA

Tel: 01424434151

Website: [www.warrior-squaresurgery.co.uk](http://www.warrior-squaresurgery.co.uk)

Date of inspection visit: 15 June 2016

Date of publication: 22/07/2016

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

## Ratings

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

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	11
Areas for improvement	11

### Detailed findings from this inspection

Our inspection team	12
Background to Warrior Square Surgery	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	14

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Warrior Square Surgery on 15 June 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

- Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day. However some patients did find it difficult to get through on the telephone in the mornings.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice employed a nurse practitioner who worked closely with the GPs to help manage some patients with more complex illnesses at their homes and in the surgery.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

Ensure that all non-clinical staff complete infection control training and record all training formally.

# Summary of findings

To continue to monitor any changes made to try to improve patient access to appointments particularly via the telephone and to canvass patient views on access.

To look at ways of reducing the level of exception reporting in particular in relation to asthma reviews and some mental health reviews.

Continue to look at ways of increasing uptake for national screening programs in particular cervical screening.

**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?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- Non clinical staff had all undertaken training in several disciplines such as basic life support, vulnerable adult and child safeguarding, clinical governance and fire safety. Infection control training had not been completed by non-clinical staff, however we saw that an elearning package had recently been purchased to allow all staff to complete this training.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Exception reporting for asthma reviews and some mental health reviews was higher than the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

### Are services caring?

The practice is rated as good for providing caring services.

Good



# Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example they were involved in a pilot scheme where a member of the social prescribing team was based within the practice for two and a half days a week. Social prescribing is a service where the patient can receive help with issues such as debt, housing and benefits.
- Some patients said they did not always find it easy to access appointments via the telephone in the morning. Patients could normally speak to a member of staff, although not always their preferred GP, if they needed to. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

## Are services well-led?

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

Good



- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 governance meetings.

# Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had employed a nurse practitioner to work as part of her role with the practice's housebound patients. They liaised with other health care agencies via a mobile phone that by-passed the surgery's system. With the patient's consent, they also worked with family members.
- The nurse practitioner reviewed the local admissions dashboard daily to identify admissions and discharges from hospital.
- The nurse practitioner managed the admissions avoidance register.

### People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading was 140/80 mmHg or less was 84% (clinical commissioning group (CCG) average 82%, national average 78%).
- The practice nurse and GP diabetic leads met weekly to discuss any outstanding issues involving any patients with diabetes.
- The practice were involved in two clinical commissioning group initiatives to ensure the effective use of inhaled corticosteroids in patients with asthma and chronic obstructive pulmonary disease.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

# Summary of findings

## Families, children and young people

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

Good



- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were just below average for some standard childhood immunisations.
- All children and their siblings who were under child protection procedures were coded appropriately on their clinical system and highlighted as an alert when their notes were accessed.
- The GP safeguarding lead had bi-monthly meetings with the health visitor about any families of concern.
- A social prescribing service advisor was based in the practice two and a half days a week. This was a service where patients were helped with issues such as debt management, housing and benefits.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The percentage of women aged 25-64 whose notes recorded that a cervical screening test has been performed in the preceding five years was 72% (CCG 84%, national average 82%).
- The practice identified patients that had failed their screening appointments and sent further reminders, texts and phone calls in addition to those sent out by the national screening centre.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

## Working age people (including those recently retired and students)

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

Good



- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- A surgery was held one evening a week with bookable appointments with GPs and a health care assistant was available.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group including smoking cessation support.



# Summary of findings

- The nurse practitioner and practice manager reviewed the out of hours and walk in centre attendances regularly. This was to identify frequent attenders and establish whether there were any other measures that the surgery could put in place to support patients to attend the practice where appropriate.
- Patients could email the surgery through a practice email address. All reception staff had access to it and messages were closely monitored and passed to the appropriate department throughout the day.

## People whose circumstances may make them vulnerable

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

Good



- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The GP lead for people with learning disabilities worked closely with carers and residential home managers to complete reviews in the patient's familiar surroundings.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice were developing their Vulnerable Patients Scheme, which was a local clinical commissioning group initiative.

## People experiencing poor mental health (including people with dementia)

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

Good



- 81% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the CCG average of 82% and national average of 84%.
- The practice held a dementia register and a mental health register.
- The practice was third in the list of top ten practices in the locality for diagnosis of dementia.

# Summary of findings

- A nurse practitioner had been employed to work with patients with dementia in care homes and nursing homes as part of their role.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record was 96% (CCG average 93%, national average 88%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had close links with the community mental health team who were housed in the same building.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations and counselling services were available on the surgery premises.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 310 survey forms were distributed and 101 were returned. This represented 1.3% of the practice's patient list.

- 48% of patients found it easy to get through to the practice by phone compared to the clinical commissioning group (CCG) average of 78% and national average of 73%.
- 78% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average 81% and national average of 76%.
- 80% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.
- 77% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 79% and the national average of 79%.

The practice were aware of the difficulties that patients experienced in accessing appointments particularly by

telephone and had been trying various strategies to improve the situation and actively involved the patient participation group in discussions. They had taken advice from telecommunication experts and had increased the number of staff and incoming lines at peak times. They were currently discussing the use of a new call software system with their telecoms provider. They had also tried to advertise the use of on-line booking and had introduced electronic prescribing which they were hoping would decrease the number of calls regarding prescriptions.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards. Of the 27 patients who commented on the standard of care received, all were positive. Staff were described as excellent, thoughtful, helpful, supportive, kind and caring. Several patients included personal examples of the good quality care that they had experienced.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

## Areas for improvement

### Action the service SHOULD take to improve

Ensure that all non-clinical staff complete infection control training and record all training formally.

To continue to monitor any changes made to try to improve patient access to appointments particularly via the telephone and to canvass patient views on access.

To look at ways of reducing the level of exception reporting in particular in relation to asthma reviews and some mental health reviews.

Continue to look at ways of increasing uptake for national screening programs in particular cervical screening.

# Warrior Square 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 adviser.

## Background to Warrior Square Surgery

Warrior Square Surgery is run by a partnership of three GPs (two male and one female) who are supported by a female salaried GP. The practice is looking to recruit two further GPs and possibly a further nurse practitioner in the future as two of the current partners eventually wish to reduce their workload. They are also supported by three practice nurses, two health care assistants, a phlebotomist, a team of receptionists and administrative staff, a finance manager and two practice managers.

The GPs run shared lists, so patients can see whichever GP they wish, although patients on the practice list do have a named GP.

The practice moved out of its previous premises in St Leonards in July 2013 following a significant fire and into their current temporary premises. The current premises are on the seventh floor of an office building on the Hastings seafront. The premises have good lift access. They have recently made a decision not to try to move back in to their old premises as they remain uninhabitable and are currently looking for suitable new premises in the St Leonards area.

The practice has a list size of approximately 7,300 patients and operates from a single site at:

7th Floor, Cavendish House, Hastings, East Sussex TN34 3AA

The practice runs a number of services for its patients including chronic obstructive pulmonary disease and asthma management, child immunisations, diabetes management, Ear syringing, family planning, new patient checks and travel health advice amongst others.

Joint injections and minor surgery are carried out at the practice.

Warrior Square Surgery is open from 8.30 am to 6pm Monday to Friday. It is closed between 1pm and 2pm on Fridays for staff training.

A duty doctor can be contacted via 111 when the practice is closed between 8am to 6.30pm Monday to Friday. This 'marginal rota' is shared with GPs from another local practice.

Appointments are available from 8.30am to 12pm every morning and from 4pm to 6pm on Monday to Thursday and 3.50pm to 6pm on Friday.

Extended hours appointments are offered on one evening a week rotating around Tuesday, Wednesday or Thursday evenings from 6.30pm to 8.15pm.

When the practice is closed patients are asked to phone the NHS 111 service that will help them access the appropriate out of hours care.

The practice population has a slightly lower number of patients under 18 than the national average. There are also an average number of patients of 65+ years. There are above the national average number of patients with a long standing health condition and just above the national average number of patients with a caring responsibility. There are a lower than average number of patients in paid

# Detailed findings

work or full time education. The percentage of registered patients suffering deprivation (affecting both adults and children) is significantly higher than average for England and the local clinical commissioning group area.

The practice is a training practice for year four and year five medical students.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 June 2016. During our visit we:

- Spoke with a range of staff, GPs, nurses, a health care assistant, administration, reception and management staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members

- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 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 were provided for specific groups of people and what good care looked 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 data, this relates to the most recent information available to the CQC at that time.

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a prescription was issued for a medicine whose dosage was related to levels in the blood, without a clinician first receiving and assessing the blood results. The policy on the management of such medicines was reviewed and both clinical and non-clinical staff were reminded of the importance of following the correct protocols. We saw evidence that the event was reviewed at both clinical and non-clinical meetings.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead

member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. All nurses and health care assistants were trained to child safeguarding level two or three.

- Notices in the waiting room and throughout the practice advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and all clinical staff had received up to date training. Not all non-clinical staff had received up to date training in infection control, but we saw that elearning training had been put in place to be completed shortly. The infection control lead nurse told us that they had carried out hand washing training with staff, but that this had not been formally recorded. Non-clinical staff we spoke with told us they were not asked to clean up spillages and were able to describe how to accept clinical specimens without handling them themselves. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best

## Are services safe?

practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were not currently administering injections.

- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We saw that all staff had received a DBS check to the appropriate level for their role.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. We saw that the building's owners regularly checked the water temperatures, a role that the practice was taking over for their floor. The water was also tested to exclude Legionella and other bacteria on a regular basis. (Legionella is a term for a particular bacterium which can contaminate water systems in

buildings). We saw that the owners of the building had a legionella risk assessment carried out in late 2014. The building's owners were registered with the Legionella Control Association.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The practice had to put their plan into operation in July 2013 when their previous premises were severely damaged by fire. They had found over the last three years areas where their plan could be strengthened and amended it accordingly. They had informed colleagues in other surgeries of learning that they had gained through the experience.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 93% of the total number of points available

The practice had a higher average exception reporting than the clinical commissioning group (CCG) for mental health reviews and also for asthma reviews. For example the exception reporting for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record was 19% (clinical commissioning group average 11%, national average 13%). Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014 to 2015 showed:

- Performance for diabetes related indicators was similar to the national average. For example the percentage of patients with diabetes, on the register, who had influenza immunisation was 98% (CCG 96%, national 94%).

- Performance for mental health related indicators was similar to the national average. For example the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review was 81% (CCG 82%, national 84%).
- The percentage of women aged 25-64 whose notes recorded that a cervical screening test has been performed in the preceding 5 years was 72% (CCG 84%, national average 82%).

The practice were aware of their relatively low rates for cervical screening. They had also highlighted to us the lower than national average uptake of other national screening services such as those for breast and colon cancer. This was partly due to the significant deprivation experienced by many patients in the locality and the fact that the population was highly mobile and transient with patients constantly registering and de-registering. Many patients lived in multi-occupancy buildings, which meant that post went astray and there was a lack of engagement with pro-active services. Additionally there were some language barriers for which the practice offered translation services. The practice identified patients that had failed their screening appointments and sent texts prior to their appointments as well as further reminders, texts and phone calls in addition to those sent out by the national screening centre. They also attempted to educate patients as to the reasons for screening when patients attended the surgery.

There was evidence of quality improvement including clinical audit.

- There had been nine clinical audits in the last two years. Two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Information about patients' outcomes was used to make improvements such as: an audit in to the use of asthma inhalers led to a decrease in dose and usage in some patients with a decreased risk of side effects.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.



# Are services effective?

## (for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Not all non-clinical staff had received up to date training in infection control, but we saw that elearning training had been put in place to be completed shortly. The infection control lead nurse told us that they had carried out hand washing training with staff, but that this had not been formally recorded. Non-clinical staff we spoke with told us they were not asked to clean up spillages and were able to describe how to accept clinical specimens without handling them themselves.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and those with social problems. Patients were signposted to the relevant service including the social prescribing service. This was a service where patients were helped with issues such as debt management, housing and benefits. There was a member of the social prescribing team based at the practice.
- Smoking cessation advice was available from one of the health care assistants.

The practice's uptake for the cervical screening programme was 72%, which was lower than the CCG average of 84% and the national average of 82%. The practice were aware of and concerned by the failure of many of their patients to

## Are services effective?

(for example, treatment is effective)

attend the national screening programmes and had been making significant efforts to improve attendance. There was a policy to offer further encouragement and telephone reminders to patients who did not attend for their cervical screening test despite reminders from the centralised national screening service. They had a receptionist whose role it was to remind patients who had not attended or booked a screening appointment to do so and appointment reminders were sent by text. They ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The lower than average uptake of screening was considered to be due to several factors. The practice had a transient population with high indices of deprivation. Many patients lived in multi-occupancy accommodation and letters were lost and mislaid at their residences. Some patients despite reminders and explanations did not consider screening to be a priority.

Childhood immunisation rates for the vaccinations given were lower than CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 86% to 88% and five year olds from 92% to 93%. The practice was again aware that these figures were lower than they would wish for their patients and had raised this matter during their presentation. Their practice population was in the most deprived banding in the country and they had quite a transient population. They made significant efforts to encourage parents to have their children immunised, including phoning patients with reminders and opportunistic discussions where possible.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# Are services caring?

## Our findings

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Moveable hard plastic screens which were regularly cleaned were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations. To ensure that conversations taking place in these rooms could not be overheard, the consultation rooms were separated from the waiting/reception area by closed double doors at the end of the corridor. Clinicians went and collected their patients personally. No patients could wait outside the consultation rooms. The waiting room was a separate room off the reception area.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. All staff were DBS (Disclosure and Barring Service) checked.

All of the 29 patient Care Quality Commission comment cards we received were positive about the service experienced although five of them did have reservations about telephone access. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was average for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.

- 81% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%).
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%)
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%).
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%).
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%).

In response to patient feedback that they were not given enough time, the practice had made all morning appointments 15 minutes long (rather than 10) without decreasing the number of available appointments. Patients with complex issues could still book double (30 minute) appointments).

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.

## Are services caring?

- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. The translation services were either pre-bookable allowing a translator to be involved in a face to face consultation or a telephone translator could be booked at short notice.
- The practice booklet had a welcome message in ten commonly used languages, with a message asking patients to let the reception staff know if they required a translator.
- Signers were also bookable if required.
- A hearing loop was available if required.

### **Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 101 patients as carers (1.3% of the practice list). Written information was available in the form of carers' information and support booklet to direct carers to the various avenues of support available to them. There were posters directing patients to several carers' groups. The practice could also refer patients and carers to the social prescribing service who had an in-house representative available two and a half days a week.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation and/or by giving them advice on how to find a support service as appropriate.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example they were part of the social prescribing pilot scheme social prescribing is a service where the patient can receive help with issues such as debt, housing and benefits. In response to success of the pilot scheme, the service was now in place based in the town centre, but with a representative available in the practice two and a half days a week. The practice had a high uptake of its patients using the service.

- The practice offered a bookable extended hours service one evening a week which rotated around Monday, Tuesday or Wednesday evening from 6pm to 8.00pm. This was staffed by two GPs and a health care assistant.
- There were longer appointments available for patients with a learning disability.
- Appointments in the morning were for 15 minutes each (a double 30 minute appointment could be booked if necessary).
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- There was a nurse practitioner who visited some patients with complex needs in their homes.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, baby changing facilities, lifts, a hearing loop and translation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services as necessary.

### Access to the service

Warrior Square Surgery was open from 8.30 am to 6pm on Monday to Friday. It was closed between 1pm and 2pm on

Fridays for staff training. Appointments were available from 8.30am to 12pm every morning and in the afternoon from 4pm to 6pm on Monday to Thursday and 3.50pm to 6pm on Friday.

A duty doctor could be contacted via the practice telephone number at any time that the practice was closed between 8am to 6.30pm Monday to Friday.

Extended hours appointments were offered one evening a week rotating around Tuesday, Wednesday or Thursday evenings from 6.30pm to 8.15pm. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. Pre bookable appointments were available to be accessed online through the practice website.

Some results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were comparable to local and national averages.

- 80% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) average of 80% and the national average of 78%.
- However only 48% of patients said they could get through easily to the practice by phone compared to the CCG average of 78% and national average of 73%.

The practice was aware of the telephone access issue and had tried different ways to solve the problem and actively involved the PPG in discussions. They had taken advice from telecommunication experts and had increased the number of staff and incoming lines at peak times. They were currently discussing the use of a new call software system with their telecoms provider. They had also tried to advertise the use of on-line booking and had introduced electronic prescribing which they were hoping would decrease the calls regarding prescriptions.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Staff took details of the visit requests and passed them to the GPs via the practice intranet. The GPs triaged the

# Are services responsive to people's needs?

(for example, to feedback?)

requests and if concerned would call the patient. Staff were trained to recognise calls that may require an urgent visit and would call the GP to alert them to the issue. If they recognised that the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

## Listening and learning from concerns and complaints

The practice had an effective 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. Posters were displayed in the waiting room, a summary leaflet was available and the practice booklet available on the web site all had information on how to complain.

We looked at seven complaints received in the last 12 months and found that these were satisfactorily handled, dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints and action was taken to as a result to improve the quality of care. For example, a patient made a complaint that a prescription for the wrong medication had been sent to their pharmacy. The practice resolved the issue with the pharmacy and the patient received a verbal apology and explanation. Steps were taken to ensure that the issue could not recur and it was discussed at a significant events meeting. The patient then a written apology, explanation and reassurance. Learning was disseminated to all staff.



# 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 mission statement to deliver high quality, safe and effective care and promote good outcomes for patients in a partnership between the health professionals and their patients.

- The staff knew and understood this mission statement and their role in delivering it.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- Clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included

support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular weekly team meetings which were minuted.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted staff training days were held every two months.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

### Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys commissioned by the practice and through complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, they were aware that patient waiting times could be an issue and morning appointments had been increased to 15 minutes each (from ten minutes) without decreasing the number of appointments. The PPG were also involved in changes to Did Not Attend letters and patient information.

# Are services well-led?

Good 

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

- The practice had gathered feedback from staff through one to one chats, staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area such as the social prescribing scheme. The practice also trained year four and year five medical students.