The Guildhall and Barrow Surgery

Quality Report

Lower Baxter Street
Bury ST Edmunds
Suffolk
IP33 1ET
Tel: 01284 701601
Website: www.the guildhallsurgery.co.uk/

Date of inspection visit: 12 December 2014
Date of publication: 26/03/2015

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 6

What people who use the service say 9

Outstanding practice 9

Detailed findings from this inspection

Our inspection team 10

Background to The Guildhall and Barrow Surgery 10

Why we carried out this inspection 10

How we carried out this inspection 10

Detailed findings 12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of The Guildhall and Barrow surgery on 12 December 2014 under our new approach for primary medical services.

We found that The Guildhall & Barrow surgery provided a good service to patients in all of the five key areas we looked at. The practice provided a good service to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

There were systems in place to provide a safe, effective, caring, responsive and well led service. Patients and staff were kept safe because processes and procedures were being followed. Safety incidents were thoroughly investigated, analysed and learning opportunities had been identified. Robust infection control procedures were in place.

The practice was a caring practice with high quality committed GPs who provided a high level of personal care to their patients through the use of a "personal list" system. The staff were very committed to acting in the best interests of the patients. For example older patients were offered double and triple appointments in order that they could discuss multiple and complex issues during one visit to the surgery

Patients were satisfied with the service and felt they were treated with dignity, care and respect and involved in decisions about their care and treatment.

The surgery had developed a philosophy to ensure staff were well trained. There was strong visible leadership in place with an ethos of learning and improvement embedded into their procedures.

Monitoring and assessment of the services provided was achieved through a range of clinical and non-clinical audits. These were clear, concise and identified areas for improvement that had been followed up by timely action.

The practice operated a personal list system whereby each patient had a named GP. Families often shared the same named GP and this allowed GPs to identify the needs of family carers more quickly. Patients confirmed to us that they valued the personal list arrangement highly, as they felt that it afforded them personalised care from a GP that they knew and trusted.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Systems and processes in place were thorough and robustly monitored. The practice learned when things went wrong, through analysis and the identification of improvement areas. These were cascaded to staff at team meetings and during the appraisal process.

Infection control procedures were being followed and all staff had received appropriate training.

Children and vulnerable adults were protected against the risks of abuse. A nominated lead had been identified for safeguarding and staff had received training relevant to their role. There were sufficient numbers of skilled and qualified staff at the practice and they were trained to provide the services offered. There were clear systems to ensure that staff and patients were safe.

Are services effective?

Good

The practice is rated as good for effective. Patients received assessments that met published guidance from both the GP and nurse working at the practice. Staff at the practice were all qualified to carry out their roles. They were supported in the workplace through regular appraisals, training was provided and it met the needs of patients. Staff could access opportunities for learning and development. New staff to the practice went through a robust recruitment procedure, followed by an induction period to familiarise themselves with the systems in place.

Patients' conditions were monitored regularly. Audits were in place to check on the effectiveness of treatments and medicines. Care plans were in place for those requiring additional support.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for most aspects of care. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them.

We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing effective services. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that emergency appointments were available the same day.

Facilities and the premises were suitable for patients and there was ready access for the disabled. Waiting times, appointments and seasonal demand was monitored regularly and changes made to staffing levels and the number of appointments available at peak times. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. There was a clear leadership structure. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients and this was acted upon. The practice had an established patient participation group (PPG). A PPG is a forum made up of patients and staff who meet to share information and help influence changes and improvements in general practices. There was evidence that the practice had a culture of learning, development and improvement.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice was providing a good service to older people. The practice population was older than the national average and the practice had made arrangements to ensure that this patient group was cared for in a proactive and effective way. Older patients were offered double and triple appointments in order that they could discuss multiple and complex issues during one visit to the surgery. The practice offered home visits to patients who were unable to attend the surgery, including routine health checks. Through the personal GP list approach, GPs were able to establish long term relationships with families. This helped the practice to identify patients who had become family carers and to signpost these patients to organisations that could support them. The practice had formed strong links with Suffolk Family Carers and Crossroads. Care plans were in place for vulnerable older people and this information was made available to out of hours services so that appropriate care could be given to patients at all times.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice for annual and half yearly reviews of their health. Appointments were available with the practice nurses for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed longer appointments and home visits were available. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

People whose health prevented them from being able to attend the surgery received the same service from the GPs who arranged visits to them at home (including patients in the local care home the practice supports). Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

The practice is rated as good for families, children and young people. A child protection register was being used at the practice and those at risk monitored for concerns of abuse. All relevant staff had received child protection training.

Summary of findings

An effective system was in place to contact patients who were due for their cervical screening test. Chlamydia screening was available for patients between the ages of 16 and 24 and advice on contraception was available.

Childhood immunisation programmes were in place and monitored for compliance with national targets. All staff were aware of Gillick competence so children aged 16 and under could obtain an appointment with the GP or Nurse without an adult being present.

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 offer continuity of care.

The practice offered appointments up to 6.15pm and telephone consultations with the nurses or GP's were available each day. Appointments could be booked up to two weeks in advance and could be booked or cancelled on-line, or in person or by telephone. Working age and student patients could book appointments at an evening surgery if they could not attend the practice during work/college hours.

Patient choosing to have an influenza vaccination were able to have this on a Saturday morning (for a limited number of dates) at either of the two surgeries.

Repeat prescriptions were also available on-line after registering for this service. The practice offered health check for patients who were otherwise healthy, to establish whether there were any medical issues apparent, such as raised cholesterol levels or hypertension. Lifestyle advice was also available for smoking cessation, alcohol or weight loss.

People whose circumstances may make them vulnerable

Good

The practice was aware of its population and had identified groups of patients who may have poor access to primary care. The practice had established relationships with local representative organisations in order to provide the most appropriate care for vulnerable groups. A data sharing agreement was in place with FOCUS 12, a national drug and alcohol rehabilitation charity based in Bury St Edmunds. Where patients consented, this allowed the practice to share clinical and prescribing information and to deliver

Summary of findings

co-ordinated care in partnership with the charity. We spoke with patients who used FOCUS 12 and they fed back to us that the Guildhall and Barrow Surgery provided a caring and supportive service which met their individual needs.

People experiencing poor mental health (including people with dementia)

Good

The practice staff feel strongly that their personal list system was key to providing high quality and continuity of care to patients with mental health issues. The practice maintained a register of patients with mental health needs.

The practice's records system alerted GPs when patients were due to have a test or to attend a review or health check. We saw evidence that patients with mental health needs were seen regularly by their GP. The practice is working to introduce the GP Mental Health Treatment Plan in order to enhance patient autonomy and to facilitate improved communication with other organisations such as the Out of Hours service. Patients taking lithium were recalled for blood, renal function and thyroid testing every 3 months, in line with best practice guidelines. However, there was scope to make this recall system more robust through the employment of the practice computer software system. The practice had a mental health link worker who provided support and advice to both GPs and patients and also provided a bridge between primary and secondary care. The link worker also saw patients who were referred by their GP. The practice also referred patients to the Suffolk Wellbeing Service where cognitive behavioural therapy might assist the individual. Where patients had memory problems and there was a risk of dementia, national guidance was followed to achieve a diagnosis and to ensure that the right support was in place.

Summary of findings

What people who use the service say

On the day of the inspection, we spoke with 15 patients waiting to see their GP or nurse. They all told us that they were very satisfied with the practice and found staff to be kind and caring. They said they thought the practice was always clean and tidy and that staff were well trained. They were complimentary about the services provided by both the GPs and the nurses working there.

All of the patients we spoke with were satisfied with the appointment system. Patients told us that they could get an urgent appointment when they needed one and if necessary they received a telephone consultation to offer advice and guidance. Patients also told us that the system for obtaining repeat prescriptions was effective and the immunisation programme for children was organised and efficient.

Prior to visiting the practice we left comment cards for patients to complete, describing their experience of the practice. We reviewed the 23 cards that were left for us. Patients were very complimentary about all the staff working at the practice and the way services were provided. They said that they had been treated with respect at all times and that their privacy was upheld. They said they had been listened to by GPs and nurses and that reception staff were friendly and helpful. Many described the practice as excellent and were very satisfied with the appointments system and the explanations given about their care and treatment options.

The results of a patient survey carried out in 2014 demonstrated that patients were very satisfied with the services provided at the practice. Where improvements had been identified, these were put into an action plan and developed to improve the services provided.

Outstanding practice

The practice operated a personal list system whereby each patient had a named GP. Families often shared the same named GP and this allowed GPs to identify the needs of family carers more quickly. Patients confirmed to us that they valued the personal list arrangement highly as they felt that it afforded them personalised care from a GP that they knew and trusted.

The Guildhall and Barrow Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and included a GP specialist advisor, a nurse specialist advisor, a second CQC inspector and a CQC pharmacist inspector and an Expert by Experience.

Background to The Guildhall and Barrow Surgery

The Guildhall and Barrow surgery is located in the centre of Bury St Edmunds and has a branch in Barrow a village approximately 6 miles from Bury St Edmunds. The practice provides services for approximately 11,500 patients from the two surgeries.

The practice partnership consists of three male and three female GPs. Three female salaried GPs are employed. At the time of the inspection a GP registrar and a foundation year 2 trainee doctor were working at the practice. Nine nurses and a healthcare assistant were employed along with a dispensary team and manager, a practice manager and a team of administrative and reception staff who support the practice.

The practice provides a dispensing services to patients entitled to this service.

The practice is open between 8 am and 6.30 pm on weekdays. Home visits and telephone consultations were available as required.

The Guildall and Barrow surgery does not provide an out of hours service to patients. Details of how to access out-of-hours emergency and non-emergency treatment and advice was available within the practice and on its website.

Why we carried out this inspection

We inspected The Guildhall and Barrow surgery as part of our new comprehensive inspection programme.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances

Detailed findings

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

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 12 December 2014. During our visit we spoke with a range of staff including GP's, practice nurses, reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. An effective system was in place to handle national patient safety alerts, significant events, complaints and safeguarding adults and children. Robust processes were being used to ensure that timely preventative action was taken when risks were identified.

Clear and complete records were maintained to provide a comprehensive audit trail for safety management. Staff we spoke with were aware of the designated leads for each area and knew the reporting procedures and followed them. They told us they were encouraged to report any incident and that their concerns were taken seriously. The practice had a 'no blame' culture and embraced the ethos of reporting safety concerns and learning from them. Staff were aware of external organisations they could report incidents to, if required and the practice had details of these organisations for all staff to refer to.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff we spoke with were aware of the requirement and procedures to report incidents, however minor.

We viewed the records held for several significant events. These demonstrated the practice had a comprehensive system in place to review, investigate and take action for improvement. Learning was shared with all relevant members of the team.

All staff we spoke with were aware of the procedures to follow and confirmed that staff meetings were used to learn from incidents.

National patient safety alerts were dealt with in an effective manner. Where necessary individual patient records were marked accordingly. The responsibility for assessing the information and any action required was clearly defined and was the role of the GP. Where patients needed to attend the practice to conduct a review of their care and treatment, an effective system was in place to notify them and offer them an appointment.

Complaints were also managed effectively. Record keeping was of a high quality and included the details of the investigation and the identification of any safety issues. Patients were included in the learning process where applicable and staff informed in a timely fashion to reduce the risk of reoccurrence.

Reliable safety systems and processes including safeguarding

The practice had a designated lead for safeguarding vulnerable adults and children who was trained to level three. Those patients identified as at risk were placed on a register and regularly monitored. Regular multi-agency meetings took place, attended by the GP lead, for the on-going management and support of patients at risk.

Vulnerable patients were highlighted on the computerised record system and this alerted the GPs and staff, when a patient on the risk register attended for an appointment. This enabled them to be monitored to ensure they were safe and referred to support agencies when required.

All staff had been trained in safeguarding and were aware of the different signs of abuse. There was a system in place for staff to report any concerns to the designated lead for safeguarding or other senior member of staff. Staff we spoke with had a sound knowledge of safeguarding procedures and knew the action to take if they felt that a patient might be at risk. The local authority reporting procedures and contact details were readily accessible to all staff.

A chaperone policy was in place that described the procedures to follow. The practice nurse had received formal chaperone training and this was cascaded to non-clinical staff so they could deputise in the absence of the nurse. Staff we spoke with were aware of the requirements of the role and where to stand when an examination was taking place. However one member of staff was unsure of the procedure to follow when acting as a chaperone. The practice manager has agreed to undertake some follow-up training to ensure all staff understand the procedures to follow. A sign was available in reception to inform patients that this service was available to them.

A system was in place to monitor patients with poor mental health who did not attend their appointments. Follow-up telephone calls were made to encourage the patient to attend and if there were concerns, these were escalated to the community nurse who checked on the welfare of a the patient.

Are services safe?

The practice had a whistle blowing policy and staff we spoke with were aware of the procedures to follow and who they could contact externally if they needed to. They told us that they felt that the managers at the practice would listen to any concerns they raised and deal with them effectively.

Medicines Management

We checked the medicines in use at the practice and found that they had been stored correctly and in line with published guidance. The practice worked in partnership with the local Clinical Commissioning Group to undertake medicines audits and monitor their prescribing patterns. This ensured they were providing value for money and using the best available products for their patients. The audits had helped to identify the over-use of certain types of medicines so that action could be taken.

Fridges used for storing vaccinations and other medicines were in a secure location and accessible to relevant staff only. The temperatures of the fridges were monitored to ensure that medicines were stored at the correct temperatures to maintain their effectiveness. A temperature record log was being maintained on a daily basis. The practice had a procedure which covered the steps to take to ensure medicines were placed in fridges as soon as possible after receiving them. Staff were aware of the procedures to follow.

Stocks of medicines were checked and rotated regularly to ensure they were not stored beyond their expiry date. We checked these medicines and found that they were all in date. Expired medicines were disposed of in line with current guidance.

The GP at the practice had a home visit bag that contained appropriate emergency medicines. These were all in date and a system was in place to ensure they were checked regularly. Records were being maintained that reflected that this was being undertaken.

Nursing staff responsible for administering vaccines could demonstrate that they were appropriately qualified and experienced to deliver them.

All prescriptions were reviewed by a GP before signing them. Blank prescription forms were securely stored and handled in line with published guidance.

Cleanliness & Infection Control

The practice had an infection control lead that was responsible for overseeing the procedures in place at the practice to reduce the risk of a health care related infection. This was the practice nurse.

We found that robust procedures were in place including cleaning checklists for clinical and non-clinical areas. An infection control audit had been undertaken in 2014 and where improvement areas had been identified, these were clearly recorded. An action plan was in place that identified the improvements required, the timescale for completion and the date when identified actions had been put into place. These action plans had been discussed at staff meetings, where applicable.

We viewed the checklists held to record the cleaning and the monitoring of the practice and found them to have been maintained to a high standard. We found the practice to be clean and tidy in all areas. Patients we spoke with were satisfied that the practice was clean and hygienic.

All staff were protected against hepatitis B and had received their vaccinations. A system was in place so that staff could receive regular blood tests to check that their immunisation status remained effective. Records were kept and we found that this was monitored effectively.

Hand washing techniques were clearly displayed throughout the practice and there was an adequate supply of liquid soaps, hand towels and alcohol hand gels. Staff spoken with were aware of the techniques to use and followed them.

Legionella testing took place annually and was in date. Legionella is a bacterium that can contaminate water systems in buildings. This test was undertaken by an external company and records had been maintained.

The practice handled clinical waste in line with guidance. It was stored and labelled correctly. An externally appointed company attended regularly to collect and dispose of clinical waste.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. These included blood pressure monitors, blood/sugar testing machines for diabetic patients, thermometers and weighing scales. They told us that all equipment was tested and maintained

Are services safe?

regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment had been the subject of an annual test and displayed stickers indicating the last test date. We saw evidence of calibration of relevant equipment, such as weighing scales and the fridge thermometer.

Staffing & Recruitment

The practice had a recruitment policy in place that described the system in place from identifying a vacancy, to a job description through to advertising, interview and selection. It highlighted the need to check experience and qualifications, registration with professional bodies and to confirm identity and the roles that require a Disclosure and Barring Service (DBS) check. This applied to both clinical and non-clinical staff. A DBS check replaced the Criminal Record Bureau check and now includes information from the Independent Safeguarding Authority to ensure people are vetted to enable them to work with vulnerable groups.

All staff including, GP registrars and trainee doctors on foundation year training, were required to go through an induction programme when they started to work at the practice. This helped them understand how the practice ran, made them aware of the processes in place and explained health and safety procedures.

There were sufficient numbers of staff on duty at all times and there was a mix of skills and experience that met the needs of patients. The practice rarely made use of locums but when they were required we saw that these were planned well in advance of any anticipated GP absences. Staff shortages were considered in advance and suitable cover arranged. Staff covered for each other during times of annual leave, training or sickness.

Monitoring Safety & Responding to Risk

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

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Staff at the practice were aware of the changes to risk or possible deterioration in patient's conditions through the regular multi-disciplinary meetings, staff meetings and clinical meeting held by the practice. Where patients who suffered from poor mental health did not attend for regular treatment, the practice had a system in place to contact them to check on their condition and to ensure that relevant medicines were being taken. They were encouraged to re-book an appointment as soon as possible and in the event of being unable to contact them, other steps were taken such as requesting a home visit by the community matron.

The practice also monitored vulnerable patients who had been discharged from hospital, or who had attended the Accident and Emergency department of the local hospital. These circumstances were reviewed and the patient spoken with to ensure that a care plan was put into place that reduced the risk of further unplanned hospital admissions. This included elderly patients, those with long-term conditions and patients with poor mental health as well as vulnerable patients. The multi-disciplinary meetings were a forum for implementing agreed and effective care plans for patients who required care from different health and social care services.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. All staff had received first aid training and the frequency of this was monitored to ensure staff received refresher training.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

Emergency medicines were readily available to staff, who knew how to access them. We found there to be sufficient

Are services safe?

quantities of the correct medicines and equipment and they were stored securely. A system was in place to monitor expiry dates. We found that the emergency medicines would benefit from being more efficiently packaged to ensure easy access if an emergency occurred. The practice had agreed to action this. Oxygen was available, in date and securely stored.

The practice had a business continuity plan in place that was available to staff in both written and electronic format. This document detailed the steps to take if there was an emergency that affected the provision of services and daily operation of the practice. It covered such eventualities as failure of the electricity supply, an illness pandemic, severe weather conditions and how to obtain alternative accommodation. Staff we spoke with were aware of its content and how to access it.

The practice had a fire safety policy. Staff had been trained to manage fire evacuation procedures and knew what to do in the event of a fire.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information, new guidance and changes to current guidelines was made available in information folders and shared with staff during regular meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments. We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Records we saw showed us that the practice's performance for antibiotic prescribing was comparable to similar practices.

The practice GPs took a lead role in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. The practice nurses carried out reviews for patients with long term conditions and carried out well man and well woman checks through pre-booked appointments. This helped the GPs to treat patients with more complex medical conditions.

Patients with long term conditions received reviews of their condition either every six or twelve months and more frequently if necessary. This formed part of the practice's own performance monitoring and data we viewed which reflected that they were achieving the targets for these reviews. The practice had identified those patients who were at risk of their condition deteriorating and offered them additional support to avoid unplanned admissions to hospital. This included older people and those with long term conditions.

Patients with long term conditions such as, diabetes and chronic obstructive pulmonary disorder (COPD) were able to attend appointments with the nurse to help them manage their conditions. They received information and guidance and their health was reviewed.

All patients recently admitted to hospital received a telephone call within three days of their discharge and their needs were re-assessed.

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

Management, monitoring and improving outcomes for people

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

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. The practice had a clear audit timetable for monitoring and assessing the services they provided. A range of clinical audits had been undertaken. These included reviewing the use and prescribing of Simvastatin and Amlodipine and Bisphosphonate medicines. Other audits included Pneumococcal revaccination in chronic renal disease, EpiPen Auto-Injectors, a review of NICE guidelines for Type II Diabetes and IUD (intrauterine contraceptive device).

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. We looked at the data and information we held about the practice. This included information taken from the Quality Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was in line with or higher than the local and national average, demonstrating that they were providing effective assessments and treatments for patients with a range of conditions such as diabetes, dementia, learning disabilities and mental health disorders and those with life limiting conditions. For example, 92% of patients with

Are services effective?

(for example, treatment is effective)

diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes and chronic obstructive pulmonary disease (lung disease).

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The national childhood immunisation programme had been implemented and performance in this area was being monitored and targets achieved.

The practice administrator was responsible for sending out letters inviting patients with one or more long term condition to attend their annual reviews. Patient attendance was monitored and followed up to help ensure that patients attended their review appointments

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

Effective staffing

The practice had effective arrangements in place for managing staff. Where possible the practice used the same locums to ensure continuity of care. Locums received a comprehensive induction and the practice tended to only use locums they knew very well.

The GPs at the practice had received an appraisal and a date for revalidation. Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

The nurses working at the practice had the necessary skills, qualifications and experience to carry out their role. They were given time to undertake their continuous professional development over a five year period, to enable them to keep up to date with their skill levels.

Nurses had received appropriate specialist training in delivering the services provided. These included managing patients with long term conditions such as asthma or diabetes, providing immunisations for children and adults, cervical smear testing and smoking cessation advice.

Staff we spoke with told us they had an opportunity to discuss their training needs either at informal meetings or at their annual appraisal. A training needs form was used for this purpose. We were told that staff were encouraged to develop themselves and that training requests were supported whenever it met with the needs of patients.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example dealing with difficult patients. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example around administration of vaccines, cervical cytology and phlebotomy. Those with extended roles (seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care

Are services effective?

(for example, treatment is effective)

providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice managed blood test results and patients were advised when to contact the practice to obtain them. Any adverse results that had been received were monitored to ensure patients received them. If they had not called the practice they were contacted directly and advised to attend to see the GP for a follow-up consultation.

Information from other health care providers such as discharge letters or emails, were assessed by the GP and placed on the patient's record. Where action was required patients were contacted and care and treatment provided.

Quarterly health visitor meetings had been recently implemented. The minutes of these meetings demonstrated that children under the age of 4 years who had health care needs and who were on the Child Protection Register had been included in these discussions.

Partnership working was evident across the patient population including Macmillan nurses, community matrons and care workers. The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents and those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. We observed how these were conducted and saw a particularly effective level of integrated working and agreement about the provision of treatment. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used a computerised patient record system known as 'SystmOne ' and staff made effective use of it. Consultations, test results and out-patient outcomes were saved into the system so all staff could access the latest information about a patient to enable them to meet their needs. The system was used to record all relevant details about patients on their records. This ensured all staff at the practice had timely information about a person's care and treatment. We found that the GPs and nurses at the practice updated these patient records after consultations and without generating a backlog.

The patient record system was used effectively and all staff had access to it. It was used for performance monitoring across all key health performance areas as well as providing staff with tasks to complete to ensure patient's needs had been actioned.

We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. Hospital discharge letters were brought to the attention of one of the GPs for review, action taken if necessary and the patient's record updated in a timely manner.

Information from Accident and Emergency attendance by patients and 'out of hours' consultations, were sent to the practice the following morning and actioned the same day. This was then reviewed, follow-up action taken if necessary and the details added to the patient record.

A 'choose and book' system was in use that enabled patients, referred for specialist treatment, to select their preferred hospital.

Consent to care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of the practice's consent policies and procedures and told us that they obtained patient's consent before carrying out physical examinations or providing treatments. Both nurses we spoke with were aware of parental responsibilities for children and they told us that they obtained parental consent before administering child immunisations and vaccines.

Clinician's demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Nurses and GPs we spoke with were aware of the Mental Capacity Act 2005 as it relates to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so by ensuring that any decisions made on their behalf are in the person's best interests.

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

New patients to the practice were given an information pack to complete to provide information about their history and medical conditions. They then received an appointment with a nurse to assess their health. If an issue was identified, the patient would be referred to a GP for a follow-up appointment.

The practice offered NHS health checks to all its patients aged 40-75 years. When patients were seen by the nurse and if any issues were identified they were referred to the GP for a follow-up appointment.

The practice provided health promotion information to its patients. The practice nurse provided advice on smoking cessation and diet to encourage patients to live a healthy lifestyle. Patients had been referred to external agencies that provided exercise groups classes, or for advice about dietary habits. A range of literature was available for patients in the reception area. Patients eligible for flu vaccinations were reminded of their availability through posters displayed on notice boards in addition to being contacted directly to advise them that they were due. This also included infant immunisations as part of the national programme for young children.

The practice kept a register of all patients with a learning disability and patients were contacted and offered an annual health check. The practice was achieving the targets set for them in the CCG area. The practice had a programme of cervical screening for their patients. The nurses at the practice contacted patients who were eligible and followed up test results and where relevant follow-up appointments were made with the GP.

The practice also offered a range of immunisation vaccinations for children as part of a national programme of inoculations. The practice was monitoring its own performance in this clinical area and were achieving the targets set. Travel vaccinations were also available.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of patients undertaken by the practice's Patient Participation Group. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at listening to them and saying the GP gave them enough time.

Patients completed comment cards to provide us with feedback on the practice. We received 23 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. There were no negative comments made in these replies. We also spoke with 18 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy had been respected.

Staff and patients told us that the practice had a policy to provide continuity of care whenever a patient moved into a care home, if this was within their practice area. This ensured that patients' wishes to remain with their chosen GP were upheld.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice telephone answering system was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to encourage only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions around their care and treatment. Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

All patients at the practice received continuity of care through the system of a named GP for each patient. Patients told us this arrangement was valued as they received good continuity of care from GPs that they knew and trusted. Some families shared the same named GP and this had led to quicker identification of and support for family carers.

We saw evidence of several care plans for older patients who had been involve in agreeing these. These plans sometimes included information and decision making about end of life planning and resuscitation wishes.

Three children who were with their parents told us they had been treated as individuals by all the staff at the practice and had their health care needs explained to them by the GPs.

The results of the practice survey reflected that patients were very satisfied with the consultations and the information they received form the GPs and nurse. The 23 CQC comment cards that were completed also reflected high levels of satisfaction amongst patients for being involved in the decisions around their care and treatment.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with told us that all staff at the practice were compassionate and offered support when it was needed.

The practice took positive steps to identify those in need of extra support from carers or those who were carers themselves. Carers were offered a health check to ensure that their needs were being met and they were also signposted to other services that could provide additional support such as financial benefits or where to obtain mobility aids. Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Literature in the form of leaflets and posters were displayed in the waiting room area signposting a number of support groups and organisations that could be accessed for patients, relatives and carers. These included information about support for those suffering from long term conditions such as cancer and diabetes and advice for carers in relation to equipment and benefit payments. Literature available included Age concern, Age UK and a carer's advice leaflet.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of services provided. The practice understood the needs of the patients and they were tailored to their needs to ensure flexibility, choice and continuity of care. Performance was then monitored to ensure that they provided high quality care and treatment.

The practice demonstrated that they considered the needs of different people in vulnerable circumstances. Although the practice monitored their use of medicines to obtain best value for their patients both in terms of cost and effectiveness, they were aware that changes of medication affected those with poor mental health. Prior to making any decisions about changing a patient's medication, they also considered the impact this had on those who were vulnerable. Each patient was therefore treated individually and where the change of medication may have had some financial benefits, if these were outweighed by the needs of the patient then the medicine was not changed.

Home visits were available for older people, those with long term conditions and those with limited mobility. Time was also set aside each day for telephone consultations if they were considered necessary.

Although patient appointments lasted ten minutes, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities and older people or if patients had complex needs.

Patients we spoke with told us that they were satisfied with the appointment system. They never felt rushed by the GP or the nurse and commented that they were listened to and their needs were understood. Patients told us that they rarely had to wait until the next day to obtain an appointment and if it was urgent they could usually get to see the GP or nurse on the same day.

The nurse at the practice provided antenatal and postnatal care for mothers and babies.

The nurse also saw patients who had minor illnesses and minor complaints and was qualified to do so. This allowed the GP to concentrate on the more complex issues. Patients we spoke with told us they were satisfied with this service and received appropriate care and treatment.

Patients were able to request repeat prescriptions by email or to attend the practice personally. Prescriptions would be ready within 48 hours but patients we spoke with told us that they were often ready for collection earlier.

Tackle inequity and promote equality

The practice was available for patients to register with regardless of their personal circumstances or vulnerability. This included the homeless, members of the travelling community, persons living with mental health, those with learning disabilities and any other vulnerable group. Patients from different cultures, religions and beliefs were welcome to register at the practice. A registration pack was available for all patients and all newly registered patients were offered a health check with the nurse.

Although the majority of patients at the practice were English speaking, if translation services were required, staff were able to contact an interpreter service if they needed it.

The premises and services available met the needs of people with disabilities. There was ample space for wheelchair users, all consultation rooms were accessible and suitable toilet facilities were available.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients we spoke with, feedback left for us on CQC comment cards and the results of patient surveys reflected that patients were generally very satisfied with the appointment system and that it met their needs. We found

Are services responsive to people's needs?

(for example, to feedback?)

that the practice regularly reviewed the demand for appointments and made seasonal adjustments to the number available at peak periods and also increased staff numbers to take telephone calls during these times.

Appointments with the GP and nurse were available in the morning and afternoons on each day of the week. The practice offered 61 GP sessions across their two surgery sites that included a late evening offered at their branch surgery in Barrow for patients who were at work and could not attend daytime appointments.

Times had been allocated each day to provide telephone consultations for patients requiring advice or a consultation. The GP also made home visits to patients who were too ill to attend the surgery or who were housebound had limited mobility. We found that the practice had arrangements in place to meet the needs of some elderly patient who were living in care homes. One patient told us they had been provided with excellent care whilst living in a local residential care home. We were informed by two care homes and by relatives that the practice had always responded and visited patients very quickly whenever they needed to see a GP.

Patients with long term conditions were reviewed by the nurses working at the practice as part of the general appointment system rather than through weekly clinics. Appointments were available at a time that suited patients and we found that access to the nursing staff met the needs of patients.

Patients with learning difficulties or those with poor mental health were reviewed annually and given double appointment times to ensure that all health issues could be covered without them feeling rushed.

Routine appointments with GPs and nursing staff could generally be obtained within 72 hours. Patients with an emergency or with children who were ill would be seen the same day and prioritised.

Appointments for patients eligible for flu vaccinations could be obtained throughout the week and on specific Saturdays that the practice had advertised. These included the elderly, those with long term conditions and those who were vulnerable.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. This person was responsible for the initial investigation and for recommending resultant action to be taken by the practice. This was then ratified by a more senior colleague.

The complaints procedure was available in a prominent place in reception with a form for patients to complete. The policy was also outlined in the practice leaflet to advise patients of the procedure. Patients were encouraged to make any complaint they had either verbally or in writing and all complaints were recorded, even if of a minor nature.

All staff we spoke with on the day of the inspection were aware of the complaints procedure and were able to advise patients if they asked about this. They knew who the designated person was who handled complaints and they would normally refer the complainant to them.

We looked at the records for the six complaints received in the last twelve months and found these were investigated thoroughly and sensitively. All complaints whether written or verbal were recorded and investigated consistently in line with the practice's complaints procedures. Records we viewed showed that there were learning outcomes from complaints where appropriate and that these were shared with staff to help improve practices and patient care.

Are services well-led?

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

Our findings

Vision and Strategy

The senior GP partner and three other GPs shared their ethos for the practice which was to deliver the very best care for patient. They strived to achieve this by creating an open and honest culture in which challenge, innovation and learning could thrive. The practice chose to drive this vision through day to day decision making and practice meetings, rather than embedding it by means of a written mission statement. Our conversations with staff and patients demonstrated that this approach was effective as everyone we spoke with was able to articulate the values of the practice, namely 'high quality care'. All clinical, dispensary, administrative and reception staff that we spoke with shared these same goals and demonstrated commitment to and pride in the service.

The results of the patient survey and the comment cards we viewed confirmed that the strategy was effective and being monitored and reviewed in order to achieve the stated aims and objectives.

Governance Arrangements

There was an effective governance framework in place to support the delivery of good quality care. Policies and procedures at the practice were available to all staff. There was evidence that the policies and procedures had been reviewed and updated giving the rationale for the update. The policies and procedures in place to govern activity were available to staff via the desktop on any computer within the practice. We looked at ten of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All ten policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear structure in place with a range of different staff across the practice taking lead roles. This included both administrative and clinical staff for such topics as, safeguarding, child protection, care homes, palliative care, prescribing and information and clinical governance. There were a range of policies and procedures that described the way the practice managed key areas of performance and the standards expected. There was a health and safety policy which had been reviewed and a risk assessment covering the risks to patients and staff. The policies were the subject of regular review and were fit for purpose.

Staff we spoke with were aware of the clinical leads and who to speak to if they needed advice. They had been encouraged to read the policies and displayed knowledge about their content. It was apparent that all staff were working towards achieving the standards set for them and that this was being monitored.

The different indicators within the Quality and Outcomes Framework each had a clinical 'champion', a nurse lead and an administrative lead. The Quality and Outcomes Framework is a voluntary annual reward and incentive programme for all GP surgeries in England. The staff we spoke with were clear about their roles and responsibilities, and to whom they were accountable.

The practice had a clear audit timetable for monitoring and assessing the services they provided. A range of clinical audits had been undertaken that have been referred to under the 'effective' section of this report. These audits had clear outcomes that included the resulting actions that had been taken by the practice these were clearly identified outcomes that not only improved the services they provided but that were having a positive effect on patients.

The practice held regular governance meetings. We saw that items for discussion included significant events, complaints and compliments and training.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as Control of Substances Hazardous to Health (COSHH), asbestos, fire safety, buildings maintenance, access to appointments and prevention of the legionella virus. We saw that the risks were regularly discussed at team meetings and updated in a timely way.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We found that there was strong, visible leadership at the practice with a positive approach towards teamwork. All staff were engaged in defining the practice's vision for high standards of care and were encouraged to involve themselves in future developments. Regular team meetings took place where issues were openly discussed. Where a member of staff wished to raise something in confidence, this was dealt with in a way that maintained their privacy.

Are services well-led?

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

Staff told us they felt supported and that their training and development needs were being met and that appraisals were effective and meaningful. They felt included in the future of the practice and that the GP and managers were effective leaders. They told us they could raise any issues either personally or at staff meetings and knew which external organisations to contact if there was a need.

Practice seeks and acts on feedback from users, public and staff

The practice actively sought the view of patients by inviting them to comment online and also when they visited the practice.

The patient Participatory Group report 2013-2014 that was available on the practice website had agreed several action points after meeting and discussing these with the practice. Actions agreed included: appointment booking and options to book, cancel and amend routine appointments booked online; options to receive text messages confirming appointments; news section on the practice website; on-line repeat prescription ordering and improved links to reliable medical information via the practice website. All these functions had been put into operation.

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality patient care. We saw that there were robust arrangements for learning from incidents, significant and serious events and complaints. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed.

Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

The practice partners told us they believed that training junior doctors protected their future and was an excellent source of stimulation and inspiration. At the time of this inspection there was a GP registrar and a foundation year two doctor training at the practice. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

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