# Spring Street Surgery

## Quality Report

The Bourne Hall Health Centre,
Chessington Road,
Ewell,
Epsom,
KT17 1TG
Tel: 020 8394 1362
Website: www.springstreetsurgery.co.uk

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

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |
| Are services safe? | Requires improvement |
| 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



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out a comprehensive inspection of Spring Street Surgery on 18 November 2014.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, caring, effective, and responsive services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). It required improvement for providing safe services.

Our key findings were as follows:

- There were a range of appointments to suit most patient's needs
- Patients reported good access to the practice and a named GP or GP of choice, with urgent appointments available the same day.
- The practice engaged effectively with other services and agencies to ensure continuity of care for patients.
- Patient feedback showed that patients held the practice in high regard. They were involved in making decisions about their care and were treated with kindness and respect.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure there are clear arrangements in place for the management of out of date medicines.

The provider should:

- Ensure that patient information is clearly displayed for requesting chaperones
- Ensure staff are supported to participate in training and development according to their job roles

# 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?**

**Requires improvement**

The practice is rated as requires improvement for safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, some medicines were found to be past their expiry date and some controlled drugs had not been disposed of in accordance with legislation. Some staff had not received up to date training in basic life support.

**Are services effective?**

**Good**

The practice is rated as good for effective services. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Multidisciplinary working was evidenced.

**Are services caring?**

**Good**

The practice is rated as good for caring. Data 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

**Are services responsive to people's needs?**

**Good**

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the 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, a named GP and continuity of care, with urgent appointments available the same day. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

**Are services well-led?**

**Good**

The practice is rated as good for well-led. The practice had a clear vision and staff were clear about the vision and their responsibilities

# Summary of findings

in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions and had attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

### Older people

Good

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

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services. The practice offered GP personal lists and all patients over 75 had been contacted in writing to advise them of their named GP.

Patients over 75 were able to book a health check with the Practice Nurse or Health Care Assistant and this was promoted on the practice website and leaflet.

Patients who had been identified as having a greater risk of admission to hospital were kept under review and offered greater access to GP services. For example, a practice bypass telephone number had been provided for other care providers. Older patients with complex care needs had personalised care plans that were shared with other health and social care providers to facilitate continuity of care.

Any A&E admissions in this patient group were reviewed at monthly management meetings. In addition, these patients were contacted by their GP within 3-7 days of discharge from hospital to discuss their health. Patients told us the practice was responsive to the needs of older patients, including offering home visits and same day appointments for those with complex needs.

The practice had safeguarding processes to protect vulnerable patients from abuse. Staff were aware of the process and were able to describe what action to take if they suspected abuse or had concerns. A chaperone service was available to all patients.

### People with long term conditions

Good

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

Appropriate monitoring and reviews were undertaken to support patients to manage their conditions and to try and prevent deterioration in their health. Patients with chronic obstructive pulmonary disease (COPD), asthma, dementia or a severe mental illness were offered an annual review and were regularly invited by letter to attend the practice. COPD and asthma reviews were carried out by a Practice Nurse. Mental health clinics and dementia reviews involved other health and social care professionals.

# Summary of findings

Diabetic patients were seen every six months within a multi-disciplinary setting which involved dietetics, podiatry, Practice Nurse and a GP review. An interim review was carried out by the patient's registered GP with up to date blood tests prior to the review being undertaken to inform future health monitoring planning.

The practice endeavoured to review their patients with rheumatoid arthritis at least once a year.

Hypertensive (high blood pressure) patients were monitored regularly by their GP and the nursing team.

When needed, longer appointments and home visits were made available to patients.

Patients who had been identified as having a greater risk of admission to hospital were kept under review and offered greater access to GP services. For example a practice bypass telephone number for nursing and social care providers to enable ease of access to the GP. Each patient in this group had an individual care plan and admissions to A&E in the preceding month were reviewed at monthly management meetings. In addition, patients on this register were contacted by the practice within 3-7 days of their discharge from hospital to discuss their health.

The practice had safeguarding procedures in place to protect vulnerable patients from abuse. Staff were aware of this and were able to describe what action to take if they suspected abuse or had concerns.

**Families, children and young people**

Good

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

Appointments were available outside of school hours and the practice ensured that children needing an urgent appointment would be seen the same day.

Children were seen with their parents in pre-booked appointments. If necessary they were referred to other services. For example, health visitors/school nurses/paediatricians and the sure start programme. There was evidence of good communication and collaboration between the practice and other agencies including midwives, child and adolescent mental health services and other support organisations.

The practice had safeguarding procedures in place to protect children from abuse. Staff were aware of this and were able to describe what action to take if they suspected abuse or had concerns.

# Summary of findings

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

Good

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

The practice provided the full range of general medical services, as specified on the website and practice leaflet. The practice recently started to provide a weekly extended hour's clinic between 6.30 and 8.10 pm for patients with non-urgent problems.

Patients were able to book appointments and request repeat prescriptions requests online.

**People whose circumstances may make them vulnerable**

Good

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

The practice held a register of patients living in vulnerable circumstances, including those with learning disabilities and mental health problems. Annual health checks were undertaken for patients with learning difficulties. The practice offered longer appointments for patients who required them. Patients who had been identified as having a greater risk of admission to hospital were kept under review and offered greater access to GP services. For example, a practice bypass telephone number had been provided to other care providers for ease of access to a GP. Each patient in this group had an individual care plan and A&E attendances were reviewed at monthly management meetings. In addition, patients on this register were contacted by the GP within 3-7 days of discharge from hospital. The practice had been undertaking a weekly review of some patients to provide reassurance to the patients prior to the weekend.

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 and Out of Hours.

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

Good

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

Patients on the mental illness register were offered an annual review consisting of multidisciplinary checks on their physical and psychological wellbeing. We saw evidence of effective collaboration

# Summary of findings

and information sharing with community mental health services. Staff had received training on dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations.

The practice had safeguarding procedures to protect vulnerable adults, including those with poor mental health.

# Summary of findings

## What people who use the service say

Data from the national patient survey showed that patients rated their overall experience of the practice as good. The findings indicated that 94% of patients said the overall experience at the practice was good and that 95% said they were able to get appointments when required. We also noted that 89% of patients said they would recommend the practice.

We reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service. All of the comments were positive about the service they experienced and demonstrated that patients held the practice in high regard. Patients said the practice offered an excellent service and staff were friendly, caring, helpful and professional. They said staff treated them with dignity and respect.

We spoke with seven patients on the day of inspection and the comments we received were all positive and described excellent care.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure there are clear arrangements in place for the management of out of date medicines.

**Action the service SHOULD take to improve**

- Ensure that patient information is clearly displayed for requesting chaperones
- Ensure staff are supported to participate in training and development according to their job roles

# Spring Street Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector with a GP Specialist Advisor.

## Background to Spring Street Surgery

The practice is situated in the village of Ewell and provides a range of primary care services to approximately 6000 patients. The practice has six GPs made up of three GP partners and 3 salaried GPs. There are four female GPs and two male. The practice also employs two practice nurses. The practice is open from 8.15 am until 6.00 pm Monday to Friday. There are extended opening hours on alternate Monday and Thursday evenings from 6.30 to 8.10 pm.

The practice provides clinics for particular patient groups. These include flu, antenatal care, cervical screening, minor surgery, leg ulcer and wound clinics, childhood and adult immunisations

The practice has a higher than average number of registered patients over 65 years of age for England. The percentage of registered patients suffering deprivation (affecting both adults and children) is much lower than the average for England.

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

## Why we carried out this inspection

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

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

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including the Surrey Downs Clinical Commissioning Group CCG, NHS England and Health watch to share what they knew. We carried out an announced visit on 18 November 2014.

During our visit we spoke with a range of staff including, the GPs, the practice manager, practice nurses, administrative staff and receptionists. We reviewed patient's care records and reviewed practice management policies and procedures.

We observed how staff talked with people on the telephone and in the reception and waiting area. We also reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service. We also spoke with eight patients during our visit.

# Detailed findings

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

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

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

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

Requires improvement

# Are services safe?

## Our findings

### Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, they talked to us about a recent accident in the practice where a patient collapsed in the car park and the actions they took following the accident.

We reviewed complaints received at the practice and their responses. We also looked at safety records, incident reports, and minutes of meetings where some of these issues had been discussed. In addition we looked all of the significant event records.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. These were very detailed and clearly described the event, the action taken and subsequent learning. We were told the practice did not carry out any analysis of serious adverse events in order to identify trends. However a slot for significant events was on the practice meeting agenda. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, following an accident at the practice the clinician involved identified their need for a review of their basic life support skills. We were told this had been completed and training had been updated. In addition we saw evidence that following an incident with a patient vaccine, storage arrangements had been changed. Discussions had taken place with staff responsible for ordering the vaccines in order to ensure they were clear around their responsibilities. Staff including receptionists, administrators and nursing staff told us they were aware of the system for recording and raising issues to be considered at the practice management and staff quarterly meetings. All staff told us they felt encouraged and confident to contribute to these meetings.

We saw incident forms were available at the practice. Once completed these were sent to the practice manager. We were shown the system used at the practice to ensure these were managed and monitored. We were told national patient safety alerts were disseminated by the practice manager to practice staff via email and hard copy. One of the GPs had overall responsibility for ensuring the relevant staff acted on the information received. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. We were told alerts were discussed at practice meetings to ensure all staff were aware of any relevant to the practice and if action needed to be taken. We saw minutes of meetings that evidenced this was the case.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their training, they told us they found it very useful. We discussed various safeguarding scenarios with staff and their responses clearly demonstrated they knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and Out of Hours. Contact details were easily accessible and we observed they were in a prominent place in the treatment room and GP consulting rooms.

The practice had dedicated GPs appointed as leads in safeguarding. One for vulnerable adults and one for children who had been trained to level 3 in child protection. The records we saw demonstrated they had the necessary training to enable them to fulfil this role. One of the GPs was the named lead to liaise with the local authority and other agencies in the event of a safeguarding issue arising. All staff we spoke with were aware who these leads were and whom to speak with in the practice if they had a safeguarding concern. We were informed that no safeguarding referrals had been made by the practice.

There was a system to highlight vulnerable adult patients on the practice's electronic records. The practice did not have any children on their child protection register at the time of our inspection. However the systems were in place to flag a concern in the event of a child protection issue.

We saw no evidence of a chaperone policy on display in any of the waiting areas or consulting rooms. We were informed that chaperone duties would be undertaken by

the nursing staff if required and that they had undertaken this training. Patients spoken with told us they were not aware of the chaperone policy but they had never considered it necessary to request a chaperone.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called EMIS which collated all communications about the patient including scanned copies of communications from hospitals and other health professionals. We observed this in practice. A GP was delegated the Caldicott Guardian role (a Caldicott Guardian is a senior person responsible for protecting the confidentiality of a Patients' information and enabling appropriate information sharing).

The practice had a system for identifying children, young people and vulnerable adults with a high number of A&E attendances and unscheduled attendances. These were followed up by the GPs within 3- 7 days of the attendance. In addition they had access to the clinical commissioning group (CCG) weekly report regarding unscheduled attendances by children and adults. We were informed that the practice manager circulated this information and that GPs reviewed it and followed up with patients when necessary.

### Medicines Management

We saw there were various policies regarding medicines management. For example, emergency drugs, and emergency contraception. However, there was no system or policy in place for the recording of medicines received into the practice apart from the invoices used to order the medicines. We checked medicines stored in the treatment room including emergency and refrigerated medicines. We found they were stored securely and were only accessible to authorised staff. We observed that refrigerator temperatures had been checked and recorded regularly.

We were informed that processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates apart from one which had expired on 6 November 2014. We also found that some controlled medicines that had passed their expiry date had not yet been disposed of (Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse). During our inspection we were shown evidence that the practice had contacted the appropriate agency to arrange destruction of the controlled drugs.

Vaccines were administered by the practice nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients repeat medicines were managed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We observed this in practice during our visit. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice. We noted however the cupboard where the blank forms were kept was not kept locked throughout the day although this area was not accessible to the public.

### Cleanliness & Infection Control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a contract with an external cleaning company which specified the cleaning requirements and frequencies. We observed that this was checked on a regular basis and any issues that had arisen had been brought to the attention of the cleaning company.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, and coverings and cleaning chemicals were available for staff to use. Staff spoken with were able to describe how they would use these in order to comply with the practice's infection control policy. For example, the use of personal protective equipment whilst undertaking minor surgical procedures and dressings.

We were informed that both practice nurses were responsible for monitoring infection control within the practice. Staff had received infection control training specific to their role. We saw evidence that an infection control audit had been undertaken in December 2013 and June 2014. We saw that the practice had arrangements in place for the segregation of clinical waste at the point of

generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. We saw the practice had a clinical waste contract and that waste was collected weekly. All clinical waste bins were of the rigid type, had been supplied with orange bags and were pedal operated. Sharps boxes were appropriately stored in the treatment and consulting rooms. We asked staff about the arrangements in place in the event of bodily fluid spills. They discussed and showed us the spillage kits in use at the practice and were clear about their responsibilities in this area.

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We found all portable electrical equipment had been routinely tested and displayed stickers indicating the last testing date was the week prior to our inspection visit. A schedule of testing was in place.

### Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications and registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Risk assessments had been undertaken regarding the administration staff and evidenced none of the reception or administration staff had required a DBS check.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff spoken with were satisfied with this arrangement. We were informed that all of the GPs at the practice worked part time hours and that the practice rarely used locum GPs. In the event of a shortfall of GPs one of the part time GPs would cover the shortfall. GPs spoken with confirmed what we had been told. All of the staff spoken with told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

### 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. We saw that a range of up to date risk assessments had been undertaken which included the work environment, the premises, equipment, security and health and safety.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all clinical staff had received training in basic life support. However, some of the training had not been updated. 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 we spoke with knew the location of this equipment and records we saw confirmed this equipment was regularly checked. 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 available in a secure area of the practice and all staff knew of their location. Emergency medicines included those for the treatment of cardiac arrest and anaphylaxis. (anaphylaxis is a severe, potentially life-threatening allergic reaction that can develop rapidly) and hypoglycaemia (hypoglycaemia is a medical emergency that involves a low content of sugar in the blood). All of the clinical staff spoken with were clear about the protocol in place to manage health emergencies, for example, the use of basic life support techniques and calling an ambulance.

A business continuity plan (Disaster Recovery Plan) was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details the Surrey & Sussex Area Team and NHS Property Services Department. We were informed that copies of the plan were held off site by the Registered Providers and the practice manager.

Requires improvement

# Are services safe?

A health and safety risk assessment had been undertaken on 14 November 2014 that included actions required to maintain fire safety. We saw records that showed staff had undertaken fire safety awareness training in 2013 and 2014.

Risks associated with service and staffing changes (both planned and unplanned) were included in the disaster recovery plan. For example, in the event of a GP being incapacitated due to illness or disaster the remaining GPs and or the practice manager would assess the impact on the business of the practice and implement the contingency plan to manage this.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease, asthma and health promotion. The practice nurses supported this work which allowed the practice to focus on specific conditions. We saw evidence to indicate that the practice had a diabetic clinic and that a lead GP and practice nurse were in place to support this clinic. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of these clinical areas. Other clinical staff confirmed what we had been told.

### Management, monitoring and improving outcomes for people

The practice provided us with evidence of clinical audits undertaken during the last two years. Examples of clinical audits included; monitoring a medicine used for some patients for mental health problems, safe prescribing of combined oral contraceptive pill and impaired fasting glycaemia (pre-diabetes condition). The practice was able to demonstrate changes as a result of the audits. For example, a system had been set up to ensure that previously diagnosed impaired fasting glycaemia patients had a recall for annual blood tests. 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). For example, in response to a safety alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) the practice undertook an audit of the prescribing of medicine for hypertension (high blood pressure). As a result the practice reviewed their prescribing of the drug to some patients identified at risk of ill effect.

National data showed the practice was in line with referral rates to secondary and other community care services for most conditions. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks.

We saw evidence of multi-disciplinary meetings which were held with other health professionals to support patients receiving palliative care and their families and carers. In addition we noted a representative from the clinical staff attended prescribing meetings, CAMHS meetings (Child and Adolescent Mental Health Services). We saw evidence of effective planning of care for patients with long term conditions and complex needs. We saw data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice used computerised risk stratification tools to identify patients at risk of hospital admissions and patients identified had admission avoidance care plans in place. For example, one patient had a regular appointment on a Friday to allay their fears about their health prior to the weekend.

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.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a national performance measurement tool.

QOF data showed that the practice performance was comparable with the national average. For example, the number of patients with mental health conditions who had a comprehensive agreed care plan was higher than average.

The practice was making use of clinical meetings to assess the performance of the GPs and to update their personal

Good

# Are services effective?

## (for example, treatment is effective)

learning plans. However, we were told salaried GPs were not routinely invited to the meetings within the practice. The GPs we spoke with discussed how as a group this could be improved on.

### Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support, safeguarding of vulnerable adults and children and fire safety. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Staff we spoke with told us they had undergone annual appraisal discussions and records we looked at confirmed what we had been told. We examined personnel files and found there was documentation in place that demonstrated each member of staff had a personal development plan. Staff described their appraisal discussion as being comprehensive and very helpful.

The practice nurse spoken with told us they provided support to a wide range of patients with long term conditions, such as asthma, diabetes and chronic obstructive pulmonary disorder. They had previously undergone training in these areas, however they had not recently received any update training. Records confirmed that they had not undertaken any training since October 2013.

In addition we spoke with members of the reception and administration staff. They talked about the training they had undertaken regarding safeguarding of children and adults and fire safety training.

### Working with colleagues and other services

The practice worked with other service providers to meet patient 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. All relevant staff were clear on their responsibilities for passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GPs seeing these documents and results was responsible for updating of clinical records and other actions required. All staff we spoke with understood their roles and felt the system worked well.

The practice held a register of patients with poor mental health, those with learning disabilities and those with dementia. We saw evidence of effective collaboration and information sharing with community mental health services.

The practice informed us they held quarterly multidisciplinary team meetings to discuss patients with complex needs. For example, those receiving end of life care or patients with a cancer diagnosis. These meetings were attended by district nurses and palliative care nurses. Patients with palliative care needs were supported using the Gold Standards Framework (Gold Standards Framework is an evidence based approach to optimising care for all patients approaching the end of life). The practice had a virtual ward approach whereby its aim was to prevent unplanned admissions to hospital by using multidisciplinary case management in the community. A community matron visited the practice on a regular basis to discuss frail and elderly patients and provide support to the GPs.

### Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw these systems working in practice during our visit.

The practice communicated effectively with the Out of Hours service to ensure they received care plans and notes of vulnerable patients and those receiving end of life care. GPs within the practice provided their own telephone numbers to ensure additional support for patients receiving end of life care out of working hours. The practice computer system enabled alerts to be added to patient records. GPs used this to highlight particularly vulnerable patients.

Good

# Are services effective?

## (for example, treatment is effective)

### Consent to care and treatment

Patients we spoke with and comment cards told us that clinicians always obtained consent before any examination took place.

The GPs and practice nurse we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. The practice nurse spoke about gaining consent from patients prior to undertaking cervical cytology procedures.

We found that some staff had some awareness of the Mental Capacity Act 2005 and their duties in fulfilling it. GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples of how a patient's best interests were taken into account if they did not have capacity to make decisions or understand information. Some staff told us that they had safeguarding training which covered the Mental Capacity Act 2005. They understand concerns in relation to patients with dementia and their limited ability to make decisions.

The GPs and nurse demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

### Health promotion and prevention

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions. We saw that medical reviews for those patients took place at appropriately timed intervals. Staff told us they also offered health checks with the practice nurse, to any patient who requested this. This consisted of a basic health check with the nurse, including blood pressure and urine test and this was offered to all new patients. These checks were also made available to other patients every three years.

The practice identified those patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and mental health problems. The GP partner told us the Friday surgery was particularly beneficial because they were able to identify and treat patients who otherwise may call on the emergency services over the weekend.

The practice offered a full range of immunisations for children, some simple travel vaccines, flu and shingles vaccinations in line with current national guidance.

Patients requiring support to stop smoking were offered smoking cessation advice and signposted to the local smoking cessation clinic.

We were told and we saw that the practice had a specific link on their web site regarding Health and Wellbeing which covered a number of areas. For example, mental wellbeing, smoking cessation, eat and drink healthily, time outdoors, travel actively, physical activity and volunteering. This part of the website had been monitored regularly by the senior partner GP and an analysis had been undertaken of all of the activity on the site. The evidence showed a considerable number of patients had accessed the site during the first two weeks in November 2014 and in particular regarding the physical activity aspect. We noted that the senior partner led by example in this regard, for example we noted his bicycle and all weather equipment was stored in his consulting room.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that patients rated their overall experience of the practice as good. We noted that 86% of respondents with a preferred GP usually got to see or speak to that GP and 84% of respondents describe their experience of making an appointment as good. When asked if they would recommend the surgery to someone new to the area 89% said they would and 98% of respondents had confidence and trust in the last nurse they saw or spoke to which was the same percentage for the GP. We also noted that 89% said the last GP they saw or spoke to was good at giving them enough time and 92% of patient said the last GP was good at listening to them.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 26 completed cards and all indicated a high level of satisfaction with the service experienced. Patients said they felt the practice offered an excellent service and staff were kind, efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven patients on the day of our inspection. Their responses to our questions demonstrated that they thought very highly of the GP practice and their staff. They told us that they were very satisfied with the care provided by the practice and said their dignity and privacy was always respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms which ensured that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that 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. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard. Patients spoken with told us if they wished to discuss anything in private this was accommodated. They talked about using one of the rooms on occasion to discuss confidential issues with reception staff prior to seeing their GP. Patient Participation Group (PPG) representatives spoken with told us the staff at the practice listened to their concerns and appeared to know all of the patients very well. We observed the interaction between patients and staff throughout the day and our observations confirmed what we had been told.

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

Patients told us they had enough time during consultations to ask questions and be involved in decisions about their care and treatment. GPs were aware of what action to take if they judged a patient lacked capacity to give their consent.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% said the last GP they saw or spoke to was good at involving them in decisions about their care and 90% said the GP was good at explaining tests and treatments. When asked if the last nurse they saw or spoke to was good at explaining tests and treatments 92% of patients agreed and 88% said they were also good at involving them in decisions about their care.

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. The patient survey indicated that 89% of patients said the last GP they saw or spoke to was good at giving them enough time.

Patient feedback on the comment cards we received was also very positive and reflected these views.

We saw evidence of care planning for people with long term conditions, vulnerable patients and those patients receiving palliative care.

Good

# Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. However we did not see any notices regarding this service in the reception or patient waiting areas.

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

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 91% of respondents to the national GP patient survey said the last GP they or spoke to within the practice was good at treating them with care and concern. The patients we spoke to on the day of our inspection and the comment cards we received also highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice provided extensive information to support patients and their carers to access support groups. This included a carer's resource file and information pack. During our discussions with staff it was clear that the practice provided sensitive support for bereaved patients' families. We saw copies of letters sent to families following a patient's death, and staff talked about attending funerals and sending flowers.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patients' needs and they understood their patient population. The NHS Local Area Team (LAT) and clinical commissioning group (CCG) told us that the practice engaged with them and to discuss local needs and service improvements that needed to be prioritised.

Longer appointments were made available for patients who needed them and for those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made.

Working age patients were able to book appointments and order repeat prescriptions on line. Patients reported that repeat prescription requests were processed in a timely manner.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had a proactive patient participation group (PPG). We spoke with them during our visit. They talked about their difficulty recruiting patients into the group particularly younger patients. They told us staff including a GP, practice manager and administrative staff attended the PPG meetings. In 2014 they undertook a patient survey and following the survey they suggested improvements to the practice. For example; car parking issues and telephone access in a timely fashion. We were told staff at the practice were very receptive and supportive and had put processes in place to address the issues. For example; the practice manager had assisted the PPG members to draw up a letter to the landlord regarding the parking issue. In addition we observed that the practice took the issue regarding phone access seriously. For example, liaising with the other tenants in the building to gain their views on how they might work together on looking at a new telephone system. In addition the practice manager agreed to speak with the clinical commissioning group (CCG) and NHS England regarding funding for an upgrade of the telephone system.

The survey also sought patients' opinions as to whether the practice appointments system could be improved. The findings of the survey resulted in the practice providing a combination of open access and pre-bookable and on line appointments.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were well supported. The practice talked about the demographics of the area. They told us there were no patients with no fixed abode on their register but if the need arose they could register and be treated at the practice.

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

The practice was situated in the ground floor of the premises with easy access. For wheelchair users or those who had difficulty walking there was a drop-off point adjacent to the main doors, along with marked parking bays. Inside the building, the hallways and doors were suitably wide for wheelchair users. The corridors were fitted with handrails. There was a disabled toilet downstairs and a lift for first floor access. The reception/waiting area was fitted with a hearing loop for those wearing hearing aids. Consultation rooms were spacious with sufficient room for wheelchair users.

### Access to the service

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated.

Appointments were available in a variety of formats including pre-bookable appointments, urgent same-day appointments and telephone consultations and home visits. The practice reception was open from 8.30 am to 6.00. Appointments were held between 8:15am to 11:00am and 3:30pm to 6:00pm. The surgery provided access to urgent appointments throughout the day. Late evening appointments were available to patients on one evening per week. Patients were able access an appointment with a male or female GP if requested.

The practice had its own website which provided information to patients on opening hours and appointment availability, this information was also available on the NHS Choices website. Patients could book appointments and organise repeat prescriptions via a link website. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them.

A number of comments we received from patients confirmed that patients in urgent need of treatment had

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

been able to make appointments on the same day of contacting the practice. One patient we spoke with prior to their appointment told us if they required an urgent appointment due to a specific medical condition they were always seen on the same day. Another patient told us if their child was unwell they would always been seen on the day.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed at weekends, after 6:00pm Monday to Friday and on bank holidays. 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 on the practice website, practice leaflet and appointment information advertised in the practice.

### 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. The practice manager was the lead for complaints and handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were leaflets in the waiting room to describe the process should a patient wish to make a compliment, suggestion or complaint. The practice website however did not signpost patients to the suggestions and complaints policy. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We reviewed the practice complaints log. We found there had been six complaints within the last 12 months. The practice had investigated all the complaints and implemented appropriate actions. Learning points had been discussed at meetings between the GPs, practice manager and staff and fully documented.

# 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 did not have a written statement about their vision and ethos. However all of the staff we spoke with could articulate their understanding of the practice ethos to deliver high quality care to the patients. They talked about the open door culture within the practice, the effective communication, co-operation and support.

### Governance arrangements

The practice had policies and procedures in place to govern activity. These were readily available to staff. We looked at some of these and found they were current. For example, we looked at the staff recruitment, complaints, prescribing and safeguarding policies. Staff spoken with confirmed they were aware of the policies and knew how to access them if required.

The practice had a schedule of meetings to govern its business. This included practice business meetings with regular agenda items, such as diary and staffing issues from the clinical commissioning group (CCG), significant events and complaints. We were informed these meetings involved the partner GPs and practice manager but not the salaried GPs.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed good achievement in clinical areas. They achieved the second highest scores in their CCG area in identifying patients with diabetes. They had implemented a weekly diabetic clinic led by one of the GPs and a practice nurse.

We were told regular discussions around QOF took place at the practice meetings. We reviewed some of the minutes of these meetings and they confirmed what we had been told.

The practice provided us with evidence of clinical audits undertaken during the last two years. Examples of clinical audits included; monitoring of a medicine used for some patients for mental health problems, Safe prescribing of combined oral contraceptive pill and Impaired fasting glycaemia (pre-diabetes condition). The practice was able to demonstrate changes as a result of the audits. For example, a system had been set up to ensure that previously diagnosed impaired fasting glycaemia patients had a recall for annual blood tests.

The practice had arrangements for identifying, recording and managing risks to patients, staff and visitors. We saw that a range of up to date risk assessments had been undertaken which included the work environment and the premises, equipment and a health and safety assessment.

### Leadership, openness and transparency

We were shown a leadership structure which had named members of staff in lead roles. For example, the safeguarding lead, prescribing lead and QOF lead. The staff we spoke with were clear about their own roles and responsibilities. There were monthly practice meetings for GPs. Reception and administrative staff told us they had regular support meetings and attended quarterly practice wide meetings. Staff told us that there was an open culture within the practice. They felt confident about raising concerns and that they would be listened to.

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

The practice had gathered feedback from patients through the patient participation group (PPG), annual surveys and complaints. The practice had an active PPG which met regularly, with one of the GP partners and the practice manager. We looked at the PPG report on the last patient survey which provided an analysis of the results and identified areas for action. There was evidence that the practice had implemented an action plan as a result.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistle blowing policy which was available to all staff and they were able to discuss scenarios whereby they would use the policy and procedure and demonstrated confidence to do so.

### Management lead through learning and improvement

Staff told us that they were supported by the practice. We looked at four staff files and saw that they had undergone an appraisal. There was documentation in place that demonstrated each member of staff had a personal development plan. However, we reviewed staff training records and saw that some staff were not up to date with attending mandatory courses such as annual basic life support.

# Are services well-led?

Good

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

All of the GPs within the practice had undergone training relevant to their lead roles, such as mental health and child safeguarding. All of the GPs had undergone annual appraisal and had been revalidated.

There was evidence that the practice had completed reviews of significant events and other incidents and shared with the appropriate staff via meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>How the regulation was not being met.<br>The provider had failed to ensure that appropriate arrangements were in place for the management of medicines.<br>There were medicines in the practice that had passed their expiry date and were not fit for purpose. |