Prospect Road Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 this comprehensive inspection on 11 November 2014, and visited the location of Prospect Road Surgery, Scarborough. The practice provides general medical services (GMS) to approximately 7,500 patients from Scarborough and surrounding areas.

Overall, this practice was rated as good.

Our key findings were as follows:

- Patients reported the practice provided a caring service, where people were treated with dignity and respect.
- Patients reported good access to the surgery and told us they did not have particular problems in obtaining appointments.
- The practice held regular multi-disciplinary care meetings to ensure good care was provided.
- Staff reported they felt valued and able to give feedback, and communication was good throughout the practice.

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

Importantly, the provider must:

- Ensure safeguarding policies for children and vulnerable adults are implemented, and staff are familiar with the procedures through provision of appropriate training.

In addition the provider should:

- Implement an infection control policy to be able to demonstrate adherence to infection control guidance.
- Review and if necessary update policies and procedures on a regular basis, and record these review dates.

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 as there were areas where improvements should be made. While the practice was able to evidence they had acted properly in reporting abuse and working with other agencies in some previous circumstances, some staff had not been given safeguarding training and were unsure of what might constitute abuse and how to report concerns. There was confusion among staff as to who the safeguarding lead was within the practice. A child safeguarding policy was being drafted and had not yet been seen by staff, and there was no safeguarding policy for vulnerable adults.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. Best practice clinical guidance was referenced and used routinely. People's needs were assessed and care was planned and considered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff worked well with other health and social care professionals. Clinical staff had received training appropriate to their roles and could ask for further training.

Are services caring?

Good

The practice is rated as good for caring. Patient surveys showed high levels of satisfaction. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. We saw that staff treated patients with kindness and respect and ensured 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 Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day, it was however more difficult to request a specific named GP. The practice had good facilities and was well equipped to treat patients and meet their needs. 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.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had recently undergone a management restructure and some job descriptions had changed. Some staff within the practice were developing lead roles, such as cold chain management, infection control and prescribing. There was a clear leadership structure and staff reported they felt supported by management. The practice had a number of policies and procedures in relation to the running of the practice. Some of these were overdue for review, however the practice had identified this and was carrying out a large scale review of their procedures and how they could improve.

The practice proactively sought feedback from patients and had an active patient participation group (PPG).

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 people. The practice offered proactive, personalised care to meet the needs of the older people in its population and took a multi-disciplinary approach to end of life care. When needed, longer appointments and home visits were available for older people and this was acknowledged positively in feedback from patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Summary of findings

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. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities. Clinical staff had worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Nationally returned data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. A high percentage of patients had a comprehensive care plan. The practice made referrals to other local mental health services and bereavement counselling services.

The practice had a register of those with a learning disability and these patients were invited for an annual health check.

Summary of findings

What people who use the service say

In the most recent NHS England GP Patient Survey, 91.8% of patients reported their overall experience as good or very good, above the national average of 85.8%. In addition, 88% of patients said their GP was good at involving them in decisions about their care, 90% said nurses were good at treating them with care and concern, and 87% said was it fairly easy to get through on the phone. All these results were above the national average for all practices. Areas of satisfaction which were lower included being able to access their GP of choice, with 23.8% saying they could always or almost always access their preferred GP, below the national average of 37.5%.

In the practice patient survey carried out in February 2014 the majority of patients said they felt involved and supported in making decisions about their health, and overall were satisfied with their consultation. Negative comments included not being able to access a GP of choice, difficulty with booking appointments, and late running surgeries.

We spoke with seven patients on the day of inspection, and also collected 24 CQC comment cards, which patients filled in prior to or during the inspection. General themes in the feedback were that patients were satisfied with their care, and they found the practice to be caring and friendly. Patients told us they were treated with dignity and respect, that clinicians took sufficient time in examinations and they explained results. Areas people were less satisfied with included access to appointments on the same day, struggling to get through on the phone and a longer wait to get an appointment with the GP of their choice.

Areas for improvement

Action the service MUST take to improve

The provider must:

- Ensure safeguarding policies for children and vulnerable adults are implemented, and staff are familiar with the procedures in these, through provision of appropriate training.

In addition the provider should:

- Implement an infection control policy to be able to demonstrate adherence to infection control guidance.
  - Review and if necessary update policies and procedures on a regular basis, and record these review dates.

Prospect Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a Practice Manager.

Background to Prospect Road Surgery

Prospect Road Surgery is located in linked converted and extended residential properties over three floors, and comprises of twelve consulting rooms, three treatment rooms, and two patient waiting areas, all of which are on the ground floor. There is on street parking; however there is no dedicated disabled parking space.

The practice provides a General Medical Services contract (GMS) to approximately 7,500 patients from Scarborough and the surrounding area. There are five GPs, of whom four are partners and one is salaried. The practice is a training practice and had a GP registrar in training (qualified doctors who wish to gain experience in General Practice).

Patients can choose to see either a male or female GP, there are two female and three male GP's. There are also two nurse practitioners, two practice nurses, a phlebotomist, a healthcare assistant and a team of administrative and management staff.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury.

The practice is located in the Scarborough and Ryedale Clinical Commissioning Group (CCG) area, which has higher levels of deprivation than the England average, with lower life expectancies.

The practice has opted out of providing out of hours services to their patients, this is provided by Primecare. When the practice is closed patients access this service via 111 and for emergencies they contact 999. The practice is open from 8am until 8.30pm Monday, and from 8am until 6.30pm all other days of the week, and is closed on weekends.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider was selected at random from the CCG area.

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

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

Detailed findings

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed information the practice provided before the inspection.

We carried out an announced inspection on 11 November 2014.

We reviewed all areas of Prospect Road Surgery including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GPs, nursing and other clinical staff, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hours team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents and processes used by the practice to run the service, and observed how these worked in practice.

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, including reported significant events, national patient safety alerts, and comments or complaints received from patients.

Prior to inspection the practice gave us a summary of significant events and complaints from the previous year which had been investigated and learning points discussed at team and clinical meetings, or directly with members of staff.

The records showed that staff reported incidents, including delays in the referral processes and administrative errors. Staff we spoke to were aware of how to access incident forms on the practice intranet, and were aware of their responsibilities to raise concerns. Where necessary the practice had flagged up events via an electronic monitoring system which enabled GP practices to log incidents centrally at the CCG.

GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development.

From our discussions we found that GPs and nurses were aware of the latest best practice guidelines, and these had been discussed at clinical meetings and incorporated into day-to-day practice.

Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events. We found that the practice used information from different sources, including patient safety incidents, complaints and clinical audit to identify incidents that were occurring, and could evidence a safe track record over time.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events.

Records were kept for significant events, and these were provided to us from the past year. We saw where incidents had been discussed and reviewed, and learning/action points raised as a result. Staff gave examples of when this had happened at their team meetings or clinical meetings.

There was evidence that appropriate learning had taken place, such as changes to office procedures for handling referrals. We saw from the records that investigations included discussions with relevant staff. Staff members said they were encouraged to report incidents. Any member of staff could report an incident and said they would do this to the practice manager or senior GP.

National patient safety alerts were communicated via computer alerts to practice staff. We saw that alerts were also discussed at clinical team meetings, to ensure that staff were aware of any relevant to the practice and where action needed to be taken.

We could see from a summary of significant events and complaints that in each case the practice had communicated with patients to offer a full explanation and apology, and they were told what actions would be taken as a result of the investigation.

Reliable safety systems and processes including safeguarding

The practice had previously tried to raise a safeguarding concern in May 2014, upon doing this they found that their contact details for health visitor and safeguarding teams were out of date. This was investigated as a significant event, and as a result new contact details had been added to the intranet for staff to access, and closer links were made with health visitors, so they could attend monthly multi-disciplinary practice meetings. However following this there was as yet no safeguarding policy for vulnerable adults in place at the time of inspection. The practice manager was drafting a child protection policy which the staff had not yet seen.

While clinical staff were able to describe types of abuse and how to report these, non-clinical staff were sometimes unsure what would constitute signs of abuse and were unclear how to respond. The practice had a named GP safeguarding lead but both clinical and non-clinical staff were unsure who this was and named three separate people as who they thought they should report concerns to.

Clinical staff had received safeguarding training at a level relevant to their role. While five out of the six receptionists had received some safeguarding training, only one out of four bank receptionists had received safeguarding training for children and vulnerable adults. In discussion with the provider, we found these bank receptionists could carry out

duties alone while practice meetings were held. There was therefore a risk that if abuse happened or potential abuse was reported during this time period, that the staff member did not have the appropriate training or guidance to recognise and report this. Following the inspection the practice manager contacted us to say they had now booked training for the bank receptionists.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on the practice computer system, which collated all communications about the patient, including scanned copies of communications from hospitals.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were on child protection plans were clearly flagged and reviewed, although the practice was unsure if some of this information was up to date and was working with health visitors to improve the information held. Vulnerable children were discussed at monthly practice meetings and any actions required agreed.

The practice had chaperone guidance, and there was information on this service for patients in reception and the practice leaflet. GPs described how they would offer a chaperone for intimate examinations, and showed how this was recorded as offered and accepted or refused on the patients notes.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We checked medicines stored in the fridges and found these were stored appropriately. Daily checks took place to make sure refrigerated medicines were kept at the correct temperature. The practice had recently designated a cold chain manager who was training staff in procedures around temperature checking, ordering and stock control.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had a prescribing lead, who supervised the prescribing practices of nurse practitioners. GPs reviewed their prescribing practices at least annually, or as and when medication alerts were received. We saw records of practice meetings that noted the actions taken in response to review of prescribing data. For example, patterns of antibiotic prescribing within the practice. Medicines alerts and new guidance were disseminated through the practice via practice computers or the practice manager.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice, for instance a nurse prescriber could only issue a repeat prescription for a medicine they had initially prescribed. 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. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. Prescriptions pads were stored securely, and there was a system in place to double check repeat prescriptions before they were generated.

We saw evidence that the doctors bags were regularly checked to ensure that the contents were intact and in date. Emergency medicines were available and all staff knew where they were kept in the practice.

Cleanliness & Infection Control

We observed all areas of the practice to be clean. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Patient toilets were observed to be clean and had supplies of hot water, soap, paper towels and hand sanitizer. Aprons, gloves and other personal protective equipment (PPE) for staff were available in all treatment areas. Sharps bins were appropriately located, labelled, closed and stored after use. Disposable curtains were used in consulting and treatment rooms, which were labelled with disposal dates.

There was an identified Infection Control lead, who had attended additional training for their role, and who staff were able to name. There were cleaning schedules for cleaners which detailed daily, weekly and monthly tasks. The practice had sought advice from the CCG infection control lead, and had acted on this advice, for instance by initiating some changes to cleaning rotas and the environment.

Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any

instruments, which reduced the risk of infection for patients. Equipment we checked was stored in its sterile packaging and was within expiry dates. There was a system for stock control, reordering and checking of dates.

The practice manager told us they needed to consolidate their infection control procedures as some of what they did was not written down therefore could not be evidenced. There had not been formalised infection control audits, although issues were discussed at practice meetings and staff knew how to report issues. However the practice had recognised this as an issue and was engaged in implementing formal, regular audits. There was no infection control policy, although this was being drafted.

We saw records that confirmed the practice was carrying out regular checks for legionella in order to reduce the risk of infection to staff and patients. Staff had received training in infection control and were able to describe their roles in areas such as hand washing technique and keeping the practice and equipment clean.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report maintenance issues or faults.

There were procedures in place to ensure that equipment was checked, calibrated and functioning correctly. Items of medical equipment were on service maintenance contracts where necessary, to ensure their speedy repair or replacement. We did however find the defibrillator pads had been missed off the equipment list and therefore had been due for replacement in 2010. Following the inspection the provider contacted us to say they had ordered new pads and added this item to the list of equipment with a date for review.

Contracts were in place for annual checks of equipment such as fire extinguishers, and 'portable appliance testing' for electrical items, and we saw that this had been carried out.

Staffing & Recruitment

We saw there was a rota system in place for all the different staff groups to ensure there was enough staff on duty to meet the needs of patients. There were arrangements in place for members of staff, including GPs, nursing and administrative staff to cover each other's leave. Staff we spoke with told us there were sufficient staff to enable them to do their jobs properly, and we saw minutes from staff meetings where staffing levels were discussed in relation to patient need. Bank receptionists were available to help at busy periods or to cover staff absences. GPs told us they rarely used locums, but in this event used people who were already familiar with the practice.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken on staff prior to employment. For example, proof of identification, references, qualifications, and criminal records checks via the Disclosure and Barring Service. Checks were made on registration with the appropriate professional body for clinical staff. The practice had recruitment procedures and checklists which set out the standards it followed when recruiting clinical and non-clinical staff.

Monitoring Safety & Responding to Risk

The practice had systems for reporting, recording and monitoring significant events, and maintenance issues which could cause risk to patients. Procedures in place to assess, manage and monitor risks to patient and staff safety included fire risk assessments and electrical checks.

The practice had a health and safety policy, but this had not been updated since 2003. We saw that some 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 advisor visit with the team. Some risks were assessed, such as use of cleaning chemicals, but these did not always record mitigating actions to reduce and manage the risk. Other risks, such as the practice steps becoming a slip hazard in winter were discussed during practice meetings, but this had not led to the production of a written risk assessment and action points to manage this risk.

Patients with a change in their condition or new diagnoses were discussed at practice clinical meetings, which allowed clinicians to monitor treatment and adjust it according to risk. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example for patients on palliative care there were emergency processes in place around information given to the out of hours service.

Requires improvement

Are services safe?

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. Emergency equipment was available including access to oxygen, emergency medicines and an automated defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment. Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation.

The computer system was able to be used as a practice-wide emergency pager system to summon help to the site of any emergency. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place which had been updated. This included details of how to deal with events such as loss of computerised clinical system, staff sickness, fire and loss of utility services. There were fire procedure and evacuation plans, and regular fire drills were carried out.

Staff were able to describe how they could increase capacity in response to changing demand such as cross working between reception and administrative teams, or the use of bank staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. They were able to demonstrate how these were received into the practice and disseminated via the computer system, and discussed at clinical meetings.

Treatment, assessment and investigations were considered in line with evidence based best practice, and clinical staff were able to provide examples of meetings where new guidelines and protocols were discussed. All the GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients had their needs assessed and care planned in accordance with best practice. The staff we spoke with and evidence we reviewed confirmed this was aimed at ensuring that each patient was given support to achieve the best health outcome for them. For example patients with diabetes were having regular health checks, and were being referred to other services or discussed at multi-disciplinary meetings when required. Feedback from patients confirmed they were referred to other services or hospital when required.

Staff were able to evidence where they had discussed specific care pathways with consultant physicians and with the patient to achieve the best outcome. 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.

Practice nurses told us they tended to specialise in clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. This meant they were able to focus on specific conditions and provide patients with regular support, based on up to date information. Care was planned to meet identified needs and was reviewed regularly. Active monitoring of patient outcomes took place through clinical audits and the quality and outcomes framework. The practice could produce a list of patients with learning disabilities, those with long term conditions or who were in need of palliative care and support.

The practice held a programme of multi-disciplinary care meetings to ensure patient's needs assessment remained up to date. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions.

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

The practice routinely collected information about people's care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. QOF is a national performance measurement tool. Latest QOF data from 2013-14 showed the practice performed at or above average for the majority of clinical indicators compared to the CCG area, and had an overall rating of 94.7%, which was slightly above the England average.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Referrals were routinely discussed at clinical meetings. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved.

Clinical staff were able to show examples of clinical audits, where for example patients with heart problems had been changed medication to reflect latest guidance and improvements to reviews for patients with COPD. The GPs told us clinical audits were often linked to medicines management information, requests from the CCG, or as a result of information from the QOF. The practice was able to demonstrate changes resulting since initial audits as a result of re-audit to complete the audit cycle, such as discussing medication with patients. For other audits a future date was included for re-audit to so the practice would be able to identify if the changes had led to improvements in care.

The team was making use of clinical audits 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

Good

Are services effective?

(for example, treatment is effective)

and areas where this could be improved. We saw minutes of meetings where clinical complaints or significant events were discussed and the outcomes and practice analysed to see whether they could have been improved.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. The practice worked with the CCG as requested to assess clinical outcomes for the local area relative to other practices and the CCG area.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that 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 understanding of the best treatment for each patient's needs.

Effective staffing

All GPs were up to date with their yearly continuing professional development requirements and all had either 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 NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). The practice was a training practice and supported medical students in their training.

GPs and nursing staff were given flexible protected learning time each week. Nurses were responsible for their own Continuing Professional Development and discussed subjects they had covered and audits carried out as part of this, such as uptake of cervical screening.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff received training in mandatory courses such as annual basic life support, and nursing staff had received training specific to their role, such as in sexual health or spirometry. Staff were developing lead roles, such as in infection control and cold chain management for medicines.

Staff underwent interview selection procedures and demonstrated through interview and job applications their previous skills, knowledge and experience. On starting, staff commenced an induction programme comprising subjects such as health and safety, emergency procedures, confidentiality and the computer system.

Staff did say they felt well supported, worked well as a team and could approach their managers if they were unsure of anything. All staff undertook annual appraisals which identified learning needs from which action plans were documented. Some staff were slightly overdue for their appraisals, but had received one the previous year.

Nursing staff held regular clinical supervision and discussion meetings with the GPs, as a nursing team, and quarterly with other nurses from the CCG area. There were no regular supervision sessions on a one to one basis for all staff members, although staff did say they felt confident in raising concerns or issues on an ongoing basis. There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. For example multi-disciplinary 'Gold Standards' meetings for end of life care patients had involved district nurses, GPs and Macmillan nurses. GPs and nurses within the practice worked closely together. Health visitors attended monthly clinical meetings.

The service used special patient notes, care plans and do not attempt resuscitation requests, which were updated and reviewed to ensure out of hours providers had accurate information available to them.

Information from out of hour's services was received via the practice computer system to the appropriate GP who checked as a first task each morning, and arranged follow up treatment or appointments where required.

The practice kept disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness.

Blood results, investigations and information from out of hour's providers were generally received electronically and

disseminated straight to the relevant doctor or nurse, or the duty doctor in the case of absence. Where necessary a procedure for scanning documents such as discharge letters was in place. The GP seeing these documents and results was responsible for the action required. The GP recorded their actions around results and discharge on the computer system, such as ringing a patient to discuss an abnormal blood result, or arranged to see the patient as clinically necessary.

Referrals were made within appropriate timescales, and the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner through the use of special patient notes and admission avoidance care plans. There were regular practice and clinical meetings where patients were discussed.

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 patients' care. All staff were trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Verbal consent was documented on the computer as part of a consultation. 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. Staff were able to explain how they would involve parents or carers in the consent process.

We saw examples of where those with a learning disability or other mental health problems were supported to make decisions. All clinical staff 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 & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice offered all new patients a consultation to assess their past medical history, care needs and assessment of risk. Advice was given on smoking cessation, alcohol consumption and weight management. The practice participated in initiatives such as the bowel cancer screening campaign. Flu vaccination clinics were carried out each year, and travel vaccines were available.

Staff used patient contact as an opportunity to promote good health, and patients over the age of 75 were offered health checks. The practice kept a register of all patients with learning disabilities and all were offered an annual physical health check. The practice offered a full range of immunisations for children, in line with current national guidance. There were procedures for following up children who did not attend for immunisations by the practice nurse, who could also liaise with health visitors and GPs regarding any possible safeguarding concerns.

Patients could access antenatal care and baby clinics via the midwife or nurses. GPs provided a full range of contraceptive services including emergency contraception, while nurses were able to provide more general contraceptive advice. Patients were able to access a specialist drug and alcohol service who held weekly clinics at the practice.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent patient survey data available for the practice. The 2012-13 NHS England GP patient survey showed that 91.8% of patients reported their overall experience as good or very good, and 88% said GP was good at involving them in decisions about their care, both these figures being above the national average. 90% of patients said nurses were good at treating them with care and concern, comparable to the national average.

The practice patient survey for 2014 had responses from 525 patients and showed the majority of patients felt involved in their care and supported by staff. The survey report was published in the practice website and also contained specific comments made by patients, both negative and positive, so that any patient at the practice could read these.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 24 completed cards, and also spoke with seven patients during the inspection. The majority of these were positive about the service experienced, with people describing the staff as respectful, caring and friendly. People said they were listened to by the doctors and felt involved in their care. Many people highlighted examples of where they felt they had received particularly good care, and many patients had stayed with the practice for a number of years with multiple generations of the same family registered at the practice.

Of less positive comments received, the commonest theme was people having to wait to see the doctor of their choice, or struggling to get through on the phone, which the surgery had tried to address by changing the information receptionists gave out to avoid an 8am bottleneck on the phones.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were in use in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Patients were offered the facility to speak to a receptionist in a private room if required.

Care planning and involvement in decisions about care and treatment

Patients we spoke to during the 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 confirmed patients felt listened to and involved in their care.

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care, and nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment. The surgery offered longer appointments to those with more complex conditions to allow the patient extra time to discuss their care and treatment.

People said the GPs explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language, and there was a multi-lingual electronic booking-in screen for when patients arrived at the surgery.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors, and were supported to access support services to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service, and some highlighted when they had been given additional care and support following bereavement.

Are services caring?

The practice was signposting patients and/or families to local bereavement counselling services when necessary, and also contacted patients either by telephone or home visit following bereavement to ensure they were supported.

Notices in the patient waiting room also signposted people to a number of support groups and organisations. The practice's computer system alerted staff if a patient was also identified as being a carer so they could opportunistically assess whether the person needed extra support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities. Longer appointments could be made available for those with complex needs, and where possible review appointments were co-ordinated with others, for instance a blood test, so the patient only had to attend the surgery once.

There was a chaperone policy available, and the service was advertised in the waiting area. Telephone appointments or home visits were available where required.

The practice and GPs were well established in the area, so had a good understanding of the local population and their specific needs, and this enabled good continuity of care. Patients were offered regular reviews where possible with the same named GP or nurse. Nurses tended to work in areas of specialty so built up relationships with patients over time as they attended for long term condition reviews, but were also cross trained in different areas so could provide continuity of care to a patient with, for example, two separate conditions.

The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Tackling inequity and promoting equality

The practice was in a converted building and rooms were located over three floors. There were stairs internally and no lift, however all consulting and treatment rooms were located on the ground floor. There was appropriate access into the building for people with mobility issues, and on street parking outside, there was however no dedicated disabled parking spaces, although the practice had previously approached the Local Authority for provision of one. Patients had highlighted some access issues through patient surveys, such as stiff door closers making pushchair access difficult, and these had been rectified.

Staff explained they either knew the patients' needs or asked them to ensure the right room was allocated which they could access. The practice had a register for patients who may be vulnerable, such as those who were elderly and frail or with mental health difficulties and these patients were discussed regularly at clinical meetings to ensure the practice could meet their needs.

There was a practice information leaflet available in reception. There were no leaflets available in large print or other languages, although the practice had carried out an analysis of their ethnic profile and had not identified a need for these. If needed patients were able to request them specifically. There was a multi-lingual booking-in screen in reception, and the practice could access telephone interpreter services if required.

Access to the service

Patients could telephone the surgery to make appointments, and they could also book appointments online through the practice website. Repeat prescriptions could also be ordered online or by telephone. The practice had extended opening hours in response to patient feedback, and was open from 8am until 8.30pm on Mondays and 8am until 6.30pm the rest of the week. The practice was closed on weekends.

Opening times and closures were advertised on the practice website, with an explanation of what services were available. Longer appointments for multiple conditions were available, and up to one hour appointments for long term condition reviews with the nurse. A small number of appointments were blocked out each day for patients who needed to be seen urgently. 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 instructions on how to contact the Out of Hours service. This information was also available on the website.

Feedback from patients confirmed they were generally satisfied with the appointments system, although there was some negative feedback around being able to access their GP of choice. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of

Good

Are services responsive to people's needs?

(for example, to feedback?)

their choice. Patients who were vulnerable, for instance children with learning disabilities, were identified on the computer system via special patient notes, so they could be accommodated and given fast access to a GP or nurse.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their 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.

The practice carried out a patient survey in February 2014. An action plan was then drawn up and discussed with the PPG to look at the lowest results. The practice was able to demonstrate where they had made changes in response to feedback, such as publicising more the online booking system, and creating a new role of prescriptions clerk.

Results of the patient survey were advertised on the website, and in reception for patients to see. Information on how to make a complaint was available in the practice leaflet.

We looked at complaints from the previous year, and could see that these had been responded to with a full explanation and apology where necessary, and action points for learning detailed, for instance refresher training for staff or adding extra detail to patient notes to make GP's aware of issues when the patient next attended. Details of how to make a complaint were in the practice leaflet, which contained contact details for NHS England and a complaints advocacy service, although not for the ombudsman.

Staff described how complaints and incidents were discussed at meetings, and learning was encouraged within a 'no-blame' culture.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Patients' rights and responsibilities, such as the right to be treated with respect were advertised in the practice leaflet. The practice aims and objectives were produced in an annual strategy and patient action plan. Progress on some of these objectives could then be measured through patient surveys.

Staff we spoke to understood the values and ethos of the surgery, and said they were encouraged to share views and input. The practice had identified areas where they wanted to improve, and had restructured their management and some job roles, to enable the vision and strategy to be developed.

Governance Arrangements

The practice was able to demonstrate that they had recently restructured management and some roles at the surgery to improve governance arrangements, freeing the partners up to focus on clinical work and governance. Monthly governance meetings involving all clinical staff and registrars, in addition to partners meetings and staff meetings took place. Staff across the practice said communication was good, and they were clear in their roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the computer. However not all of these had been reviewed regularly, for instance there was no vulnerable adults policy. The chaperone policy had been due for review earlier in July 2014, and the business continuity plan in December 2013. The practice manager was aware of this as an issue, and was working with the management team and senior partners to undertake a comprehensive review and update of all practice policies and procedures.

There were some systems in place to assess aspects of quality and performance, for instance through clinical audits, the results and referral systems, and equipment checks. However the health and safety policy had not been reviewed since 2003 and although some risks had been informally identified, such as patients using the surgery steps, no formal risk assessment had taken place.

Leadership, openness and transparency

The GP partners were long standing at the practice and had formed a cohesive team, able to support GP registrars and medical students. Work was ongoing to develop a clear succession plan.

Staff told us they felt well supported and could approach any colleague to ask for advice. Staff described how the practice manager kept them up to date via email with updates and news. Staff described the culture as open and honest and said they generally felt able to raise issues or concerns, and were encouraged to have an input and give feedback. Team meetings were held monthly and staff could access the minutes to these.

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

The practice had gathered patient views through surveys, complaints received, and the patient reference group. There was ongoing work to recruit more people to this group, and to ensure this was representative of the practice population.

Patient survey reports and action plans were published on the practice website for the practice population to read. The practice was able to demonstrate through action plans where they had made changes in response to feedback from the patient group and patient surveys, such as advertising online booking facilities more.

Staff reported they could feedback through staff meetings or informally, and said they were encouraged to give feedback and felt confident doing so.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring, and said they were able to ask for and access additional specialist training. The practice was a GP training practice and supported both medical students and GP registrars.

Are services well-led?

Good

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

Staff had received recent appraisals, which contained details of areas of achievement and key areas for training and development. Some work was also underway to ensure job descriptions were up to date and accurate. Nurses took ownership of their own continuing professional development and supplied the practice manager copies of certificates.

The practice had completed reviews of significant events and other incidents and shared learning from these with 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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People who use services were not protected against the risk of abuse because the registered person had not taken reasonable steps to identify the possibility of abuse and prevent it before it occurs.** 11 (1) (a)