Mark Street 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?	Good
Are services effective?	Outstanding
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Mark Street Surgery on 25 February 2015

Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also outstanding for providing services for patients with long-term conditions

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered after considering best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We also saw areas of outstanding practice:

Summary of findings

- The practice held twice monthly early morning diabetic meetings. Clinicians reviewed patients, care and treatments strategies, best practice and research guidelines and invited speakers to promote staff's learning and development.
- The practice actively screened patient blood test results to identify those that were pre-diabetic. Those identified were invited in to an appointment to discuss the risk of developing diabetes and review lifestyle choices to mitigate this risk.
- The practice provided a carer's advocacy support service. The name and contact details of the carer's advocate was displayed in the patient waiting area. In addition, three reception staff were trained as part of the practice's carer's resource team.

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

Importantly the provider should:

Ensure a standardised approach to recording written consent from patients before any minor surgery procedure.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had systems in place for monitoring safety and learning from incidents and safety alerts to prevent reoccurrences. For example; the practice carried out significant event audits to help clinician and practice based learning. All staff had received safeguarding training and staff we spoke with were aware of the safeguarding vulnerable adults and children policies in place. The practice had a GP lead for safeguarding who liaised with other agencies when necessary.

There were systems in place to ensure medicines including vaccines, were stored correctly and in date.

The practice was clean and tidy. All equipment was regularly maintained to ensure it was safe to use. The practice had emergency equipment and medication available including oxygen and a defibrillator.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. We saw examples where a complaint resulted in the practice undertaking a clinical audit of its management of acutely ill children presenting with pyrexia (high temperature). The outcome of the audit resulted in a more comprehensive use of an assessment tool of children presenting with this. In addition the audit led to a review of treatment options for ear infections, which resulted in a change in prescribing to reflect best practice.

Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG).

Are services caring?

Good

The practice is rated as good for providing caring services. Patients we spoke with and who completed the CQC comment cards were very complimentary about the service. They said all the staff (from receptionists to doctors) were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a

Summary of findings

patient-centred culture and found evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had identified the need to improve access to the appointments system and the telephone system. However patients said they found it easy to make an appointment, once they had got through on the telephone, with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for providing well-led services. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and 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.

The practice kept a register of those patients 75 and was on target to have completed 50% of the required care plans. The practice offered a named GP for these patients in line with the new GP regulations. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

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

The practice had a higher than average number of patients with long standing health conditions (64.2% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patient with long term conditions effectively.

The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected or above the national average.

Families, children and young people

Good

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

Summary of findings

Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. They had undertaken a review of children at risk and liaised effectively with other agencies and health and social care professionals in minimising risk for those children.

There was a higher than average uptake of children receiving their childhood immunisations. The practice ran weekly baby clinics with the practice nurse leading on this. They offered a full range of childhood vaccinations.

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 that reflected the needs for this age group.

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 was aware of, and identified their vulnerable patients. This was highlighted within patient records. The practice discussed any concerning patients as a team, safeguarding policies and protocols were in place and staff were trained in safeguarding vulnerable adults and children. The safeguarding lead was a GP who had received appropriate training.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability and offered longer appointments and offered home visits if required.

Health promotion leaflets were available in languages which reflected the patient population and there was access to translation services for people whose first language was not English.

Summary of findings

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).

The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. The practice regularly worked with multi-disciplinary teams and other mental health services in the case management of patients experiencing poor mental health, including those with dementia. One of the GPs had written an information leaflet for patients and this had been translated into Urdu.

Summary of findings

What people who use the service say

During our visit, five patients initiated a group discussion with us about the service they received from the GP practice. They told us that the GPs, the care they received and access to appointments were good. A member of the practice's patient participation group (PPG) told us that the practice listened to them and acted on their suggestions. As a result of one meeting with the PPG, the practice had provided some waiting room chairs with arm rests and refurbished the toilet facilities available to patients.

We received 20 completed CQC comment cards; all but one were positive about the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us they considered that the environment was clean and hygienic.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in January 2015 demonstrated they performed well with 88% of respondents who described their overall experience of this surgery as good and 86% of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care. Sixty five percent of respondents with a preferred GP said they usually got to see or speak to that GP. These percentages were all above the average results for the local Clinical Commissioning Group (CCG).

One feedback comment card identified issues in trying to get through to the practice on the telephone and this issue was an area identified for improvement in the National Patient Survey with 51% of respondents stating they found it easy to get through to this surgery by phone. This was below the CCG average. However the practice was aware of this concern and was actively seeking solutions to improve patient telephone access.

Areas for improvement

Action the service SHOULD take to improve

Ensure a standardised approach of recording written consent from patients before any minor surgery procedure.

Outstanding practice

We saw some examples of outstanding practice:

- The practice held twice monthly early morning diabetic meetings. Clinicians reviewed patients, care and treatments strategies, best practice and research guidelines and invited speakers to promote staff's learning and development.
- The practice actively screened patient blood test results to identify those that were pre-diabetic. Those identified were invited in to an appointment to discuss the risk of developing diabetes and review lifestyle choices to mitigate this risk.
- The practice provided a carer's advocacy support service. The name and contact details of the carer's advocate was displayed in the patient waiting area. In addition, three reception staff were trained as part of the practice's carer's resource team.

Mark Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP, a specialist advisor who was a Practice Manager.

Background to Mark Street Surgery

Mark Street Surgery is located in Rochdale, within the Heywood Middleton and Rochdale Clinical Commissioning Group (CCG.) Services are provided under a personal medical service (PMS) contract with NHS England. There are 8125 registered patients. The practice population includes a slightly lower number (15.4%) of people under the age of 18, and a higher number (18.4%) of people over the age of 65, in comparison with the CCG average of 16.2% and 15.1% respectively.

There are comparatively high levels of deprivation in the practice area. Information published by Public Health England, rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice opens on Mondays 7am to 6pm and 7.30am to 6pm Tuesday to Friday. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider BARDOC.

The practice has three GP partners (two male and one female) three salaried GPs (two female and one male), one nurse practitioner, two practice nurses, one health care assistant, a practice manager, a business and finance manager, reception and administration staff. The practice is a training practice and usually has two trainee GPs.

The nurse practitioner has daily clinics both morning and afternoon for patients with acute illnesses.

On line services include; booking appointments and repeat prescription requests.

The premises are purpose built and offer access and facilities for disabled patients and visitors.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

Detailed findings

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.

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 visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. There were no areas of risk identified across the five key question areas. We carried out an announced visit on 25 February 2015.

We spoke with a range of staff including four of the GPs, the nurse prescriber, a practice nurses, the health care assistant, reception staff, administration staff and the practice manager and business and finance manager on the day. We sought views from patients and representatives of the patient participation group and looked at comment cards and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Documented evidence confirmed that incidents were appropriately reported. Staff we spoke with all said that there was an open and 'no blame' culture at the practice that encouraged them to report adverse events and incidents.

Minutes of meetings provided clear evidence that incidents, events and complaints were discussed and where appropriate actions and protocols were identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 12 months. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff we spoke with knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice manager and learning disseminated to the whole team where relevant. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their ongoing professional development. We looked at some recent significant events from 2014 which had been analysed, reported and discussed with relevant staff. We saw evidence of action taken as a result of a complaint regarding the care provided to a pyrexial child (a child with a high temperature). This was investigated and analysed as a significant event. The outcome of the investigation and analysis of this resulted in a change of procedure for the management of complaints and the provision of training and mentoring to support key clinical staff.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke gave examples of recent alerts/guidance that were relevant to the care they were responsible for. They also told us relevant alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. One staff member provided us with a recent examples where they had referred patients to the children's safeguarding team. All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed two GPs as the lead and the deputy lead for safeguarding vulnerable adults and children. They had been trained to level 3 as required to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, the health care assistant and one receptionist, had been trained to be a chaperone.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. All medicines that we checked were found to be in date. The fridges used for the storage of the vaccinations were not as required, pharmaceutical fridges. The practice was aware that these needed replacing with pharmaceutical fridges and quotes had been obtained for these. Within 48 hours of the inspection the practice provided confirmation that two pharmaceutical fridges had been purchased.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Clinical audits had also been undertaken on the use of some medicines in response to alerts and we saw examples of these. Examples included the use of Simvastatin (medicine used to reduce cholesterol) alongside some medicines prescribed for hypertension (high blood pressure). The outcome of this audit resulted in a change of prescribing practice when patients required both types of medication, so that any risks to patients were minimised.

Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition. One GP had lead responsibility for specific medicines used to treat rheumatoid arthritis and changes in prescriptions of oral contraceptives had been implemented so the practice could monitor the prescribing of these.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The nurse practitioner was appropriately trained to prescribe some medicines. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Medicines for use in medical emergencies were kept securely in the treatment rooms. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. There was oxygen kept by the practice for use in case of an emergency. This was checked regularly and checks recorded. The practice also had emergency medicine kits for anaphylaxis (a severe, potentially life-threatening allergic reaction that can develop rapidly). There was a system in place for monitoring and checking of medicines carried in GP bags. This was done by the practice nurse.

Cleanliness and infection control

We saw the premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept. Comments recorded by patients on CQC comment cards referred to the practice as being clean hygienic and safe.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. The lead had worked closely for over two years with the local authority's public health department to audit the practices' policies and procedures and implement an action to plan to improve the environment and staff working practices. A refurbishment plan was in place and being followed to ensure all clinical areas reflected best practice in reducing the risk of cross infection. Staff received training about infection control specific to their role The lead for infection control checked and audited the practice to ensure staff followed procedures. Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

Good

Are services safe?

We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/ consulting rooms. Couches were washable and privacy curtains in the treatment rooms were changed in accordance with a planned schedule.

We were told the practice did on occasion use instruments that were not single use and required decontamination and sterilisation after use. Procedures were in place to ensure these were handled safely after use. These instruments were sent away for decontamination and sterilisation. Procedures for the safe storage and disposal of needles and waste products were evident. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a policy for the management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A risk assessment was available to mitigate any risks and records were available to demonstrate actions were followed in accordance with the risk assessment.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Emergency drugs were stored in a separate cupboard. There was an oxygen cylinder, nebulisers and access to an automated external defibrillator. These were maintained and checked regularly.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

Monitoring safety and 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. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff and this was supported by a health and safety handbook which included both general workplace and clinical policies and procedures for staff follow.

There was a fire risk assessment in place and the practice regularly had fire equipment tested. Records of fire equipment safety checks and fire drills to ensure the safety of patients, staff or visitors were available.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system and by a portable alarm device.

An appropriate business continuity plan was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plans and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment. 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, anaphylaxis and hypoglycaemia and suspected meningitis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a current fire procedures policy in place which identified key personnel, such as fire marshals and their duties in the event of a fire. Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All the clinicians we spoke with were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed, confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. Each clinician confirmed that they had online access to NICE guidance.

We found clinicians and staff were familiar with the needs of each patient population group and the impact of the socio-economic environment where patients lived. National data showed that the practice had a 10 per cent higher rate, than the national average, of patients on their register with a long standing health condition.

The GPs and practice nurses had completed accredited training for checking patient's physical health and the management of various specific diseases. The GPs told us they had lead responsibilities in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. A specialist nurse for chronic obstructive pulmonary disease (COPD) also spent half a day each week at the practice specifically to review patients with this long term health care need.

Clinical staff told us the practice was focused on learning and developing to improve outcomes for patients. They said they were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of long term health conditions. For example the practice nurse with lead responsibility for diabetes, the health care assistant and a trainee GP, supervised by a GP partner held twice monthly early breakfast meetings to review their diabetic patients health care needs. We heard that updated guidance and research in relation to managing diabetes and the associated health care needs was reviewed and implemented following these regular reviews. Clinical meeting minutes we reviewed supported this.

We saw the practice had implemented a strategy of identifying those patients who were at risk of developing diabetes. Blood test results for patients were routinely monitored to identify those at a pre-diabetic stage. Those identified were invited to an appointment with the practice nurse to discuss the risks, review lifestyle habits and agree strategies to reduce the risk of going on to develop diabetes.

The practice had coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register. The practice referred patients appropriately to secondary care and other services. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP.

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 patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. QOF data showed the practice performed above the national average for the local clinical commissioning group and the England average. Data showed year on year improvement in achieving QOF points since 2010. For 2013/14 the practice obtained 99.3%. In addition the practice actively monitored its performance alongside the Clinical Commissioning Group (CCG) and bench marking against quality frameworks.

GPs carried out clinical audits. Several examples of clinical audit were provided. One of the more recent clinical audits was in response to a patient complaint and looked at management of pyrexial children. Guidance, skills, knowledge and support systems were reviewed, resulting in improvements in recording of assessments of the pyrexial child and ongoing mentoring and clinical supervision of the nurse practitioner by the GP. In addition this clinical audit resulted in a review of best practice in relation to the treatment of ear infections. The outcome of this resulted in a change in prescribing practice for patients allergic to penicillin.

Examples of other clinical audits included looking at the number of patients with polycystic ovaries and polycystic

ovary syndrome and the screening undertaken for diabetes. As a result of this audit all identified patients were called in for a glucose blood test. Sixteen months later the re-audit identified a significant increase in the number of patients who had benefited from the glucose blood test. The outcome from this identified six patients as being at the pre-diabetic stage of the illness. Support was available at the practice for patients with this pre-diabetic status.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement .Discussion of audits, performance indicators and quality initiatives was evident in meeting minutes. Staff told us they were actively encouraged to contribute when discussing audits and performance indicators. They told us they received feedback through training days and at meetings.

The practice held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings. Special information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that these were comprehensive. All staff had access to a staff handbook which included a range of employment policies and procedures and included information on safeguarding and whistleblowing. Staff were up to date with attending mandatory courses such as annual basic life support. A training plan was in place for future training. We noted a good skill mix among the doctors with a number having additional diplomas in children's health, family planning, epilepsy and sexual and reproductive health.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties. Those with extended roles such as the nurse prescriber and the lead practice nurse for diabetes were able to demonstrate that they had appropriate training to fulfil these roles.

The feedback from staff we spoke with was overwhelmingly positive. Staff were passionate and enthusiastic about working at Mark Street Surgery. They told us that the patient was central to the services they provided and were clear how their contributions contributed and impacted on the whole being provided. They said they felt supported and trained to provide a good standard of service to patients.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, patients on the risk register hospital admissions and discharges and attendance at A&E. District nurses and community matron attended these meetings regularly However we heard that

members of the community psychiatric team and or social work team rarely attended despite regularly invitation. Minutes of these meeting showed that information was shared effectively.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. 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, the Children Acts 1989 and 2004 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. The practice manager confirmed that training in the Deprivation of Liberty Standards (DoLS) was being considered for inclusion on this year's staff training plan.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The practice on occasion carried out some minor surgical procedures. For these 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. The practice also had a written consent form, however the GP confirmed that this was not always used but a record was always made in the patients notes. A recent audit showed there had been three minor surgical procedures in the last six months and consent was recorded in the patients' notes for all three. One of these minor procedures also had a written consent form completed and scanned into the patient notes. To reflect good practice and promote consistency in accordance with the practice policy a standardised approach of recording written consent from patients, before any minor surgery procedure should be implemented.

Health promotion and prevention

The practice placed a strong emphasis on health promotion by having a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes, meningitis, cancer and immunisations. Some of these leaflets were available in other languages. The practice web site had a range of information and useful links for further supporting information for family health, long term conditions and minor illnesses. There was also information available about the vaccination schedules for infants and travel vaccinations with links to regions in the world to assist people in identifying what vaccinations they required.

The practice nurses held a variety of clinics including a weekly baby clinic and for specific problems and general health checks. There was a diabetic clinic, chronic obstructive pulmonary disease (COPD) for patient with respiratory disease and cardiovascular clinic for patients with problems with heart or vascular diseases or stroke. There was a lifestyle management support for example with weight management and smoking cessation. The practice also operated NHS health checks for patients between 40-74 years of age.

The practice used the NHS health checks and other health checks to actively screen patients for pre-diabetes. Where this condition was identified patients were invited to an appointment with the practice nurse to discuss their risk of developing diabetes and the actions that could be taken by the patient to minimise these risks.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered reviews with the nurse. The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice kept a register of all patients with a learning disability and they were all offered an annual health check. There were local health and support groups that they accessed and referred patients with mental health and learning disabilities needs.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The results of the National GP Patient Survey published in January 2015 demonstrated they performed well with 88% of respondents who described their overall experience of this surgery as good and 86% of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care. Sixty five percent of respondents with a preferred GP said they usually got to see or speak to that GP. These percentages were all above the average results for the local Clinical Commissioning Group (CCG).

We received 20 completed CQC comment cards; all but one was positive about the practice. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. One feedback comment card identified issues in trying to get through to the practice on the telephone and this issue was an area identified for improvement in the National Patient Survey with 51% of respondents stating they found it easy to get through to this surgery by phone. This was below the CCG average. However the practice was aware of this concern and minutes of meetings demonstrated that they were actively seeking solutions to improve patient telephone access.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff and patients informed us they were aware there was an interview room available if patients or family members requested a private discussion.

The patient electronic recording system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, where a patient had a learning disability.

We were told by a member of the patient participation group (PPG) that the practice listened to their comments at the meetings and they felt they could influence changes in the practice in the future.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed in their appointment. Comments from patients included that they felt listened to and treated with respect, and options were always discussed.

The National GP Patient Survey published in January 2015 identified 92% of respondents felt that the last GP they saw or spoke to was good at giving them enough time; 95% of respondents had confidence and trust in the last GP they saw or spoke to and 90% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments.

GPs confirmed that all patients over 75 years had a named GP and the practice was on target to have in place completed care plans for over 50% of this patient group. A coding system on the computer system in the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities.

Staff told us that translation services were available for patients who did not have English as a first language. Some patient information leaflets were available in other languages.

Patient/carer support to cope emotionally with care and treatment

Notices in the waiting room, and on the practice website told patients how to access a number of support groups and organisations. The practice staff confirmed that they were actively identifying patients who were also carers. They provided a Carers Resource Pack and offered support. The health care assistant and three reception staff had recently completed a carer's support course and contact details to access this Carers Advocacy in-house support service were displayed. In addition, there was information about recreational classes available in the local community specifically aimed at carers.

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would

Good

Are services caring?

offer them a private room to discuss their needs. A GP partner told us that the practice development plan for 2015 included reviewing the practice's end of life strategy bereavement support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had an active Patient Participation Group (PPG). We spoke with a member of the group and looked at their meeting minutes. The practice manager and a GP attended the PPG meetings on a regular basis where good information exchange took place. The PPG told us the practice listened to them and they were able to contribute views and suggestions that, if appropriate, were acted upon. There was a suggestions box located in reception which the PPG monitored and fed back to the practice any issues.

Tackling inequity and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There was a large waiting area for patients attending an appointment and some car parking was available nearby. Baby changing and disabled toilet facilities were available and plans were in place to install an induction hearing loop this year.

The practice analysed its activity and monitored patient population groups. They had tailored services and support around the practice populations needs and provided a good service to all patient population groups. The practice population spoke a variety of languages. Staff had access to translation service (language line). A number of the practice health promotion leaflets had been translated into other languages. This enabled them to direct appropriate support and information to the different groups of patients.

The training for all staff in equality and diversity was included on the practice development plan for 2015.

Access to the service

The practice was open on Mondays 7am to 6pm and 7.30am to 6pm Tuesday to Friday. They were closed one half day per month for training and development. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included information on who to contact for advice and appointments out of normal working hours and the contact details for the out of hours medical provider. The practice offered pre bookable and urgent (on the day) appointments and home visits. Appointments could be made in person, by phone or online. Priority was given to children; babies and vulnerable patients. These patients were always offered a same day or urgent appointment. The nurse practitioner also saw patients with acute health care needs.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients.

Patients we spoke with, comment cards and patient survey results told us patients were satisfied with the service they received from the practice. Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in January 2015 demonstrated they performed well with 88% of respondents who described their overall experience of this surgery as good and 86% of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care. 65% of respondents with a preferred GP said they usually got to see or speak to that GP. These percentages were all above the average results for the local Clinical Commissioning Group (CCG).

However the practice was aware that patients struggled with telephone access to the practice. The National GP Patient Survey identified that the practice was below the CCG average with 51% of respondents stating they found it easy to get through to this surgery by phone. In response to

Good

Are services responsive to people's needs?

(for example, to feedback?)

this the practice had introduced online appointment booking and prescription ordering service and was considering additional interventions to ensure patients got through to reception within a reasonable time frame.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We looked at a review of an annual summary of formal complaints received by the practice for 2014. Complaints were broken down into different categories and included whether there was a clinical element. We saw the practice responded to complaints proactively investigating the concern, responding appropriately to the complainant, identifying improvements in service quality, sharing learning and adapting practice. A number of examples were available which demonstrated the commitment of the practice to improve and develop its service. Learning points from complaints were reviewed as significant events, discussed at staff meetings and incorporated into clinical supervision where relevant.

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's aim was "To provide high quality medical care services". This was supported by a number of objectives which included, "Make patients' central to what we do and listen to their views". The practice had a clear vision to support patients to stay healthy and to provide a high quality, patient centred care to them if they were unwell. Staff told us that the vision and values of the practice was to put the patient at the centre of everything they did. All the GPs worked together to develop both short term and longer term practice development plans and these were shared with all staff.

All staff we spoke with demonstrated a commitment and enthusiasm and were engaged in providing a high quality service. Each member of staff had a clear role within the structure of the practice and there was recognition of staff members' contribution.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy in the offices. Policies and procedures we viewed were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them. Staff could describe in detail some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

There was a clear organisational and leadership structure with named members of staff in lead roles. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed above the national average for the local clinical commissioning group and the England average. Data showed year on year improvement in achieving QOF points since 2010. For 2013/14 the practice obtained 99.3%. Staff confirmed that QOF data was discussed and reviewed regularly.

Clinical audits were undertaken regularly by nursing and medical staff. Audits undertaken by the clinical staff were decided on either by local Clinical Commission Group (CCG) or national priorities but also in response to complaints and significant events. Minutes of meeting provided clear evidence that the outcome of the audits were discussed at team meetings and training and development days.

The practice had arrangements in place for identifying and managing risks. Risk assessments and risk management plans were in place.

Leadership, openness and transparency

There was a well-established clearly identified management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. They all spoke of good clear leadership which articulated vision and motivated staff to provide a good service.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice held a number of various meetings at regular intervals that were documented. These included clinical, administrative, organisational, managerial and business meetings. Examples of various meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from complaints and significant events.

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

We reviewed complaints and found they were well managed. The practice investigated and responded to them in a timely manner, and records indicated that complainants were satisfied with the outcomes. They were discussed at staff meetings and were used to ensure staff learned from the issues raised.

Are services well-led?

Good

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

There was an active Patient Participation Group (PPG) which had a good relationship with the practice. They felt listened to and valued with the practice acting on suggestions put forward by the PPG where appropriate.

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. They gave examples of reporting incidents openly and believed there was a no-blame culture at the practice, which encouraged reporting and evaluation of incidents and events. The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Regular monthly meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had.

Management lead through learning and improvement

GPs were all involved in revalidation, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals which included looking at their performance and development needs. Staff told us appraisals were useful and provided an opportunity to share their views and opinions about the practice.

The practice had an induction programme for new staff and a rolling programme of mandatory training was in place for all staff. Staff undertook a wide range of training relevant to their role and responsibilities relevant training. Records of staff training and copies of training certificates were available.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice had training and development half days each month. The practice was a GP training practice and we found that trainee doctors were well supported by the GPs and other staff.

The practice had completed reviews of significant events, complaints and other incidents and shared the learning from these with staff at meetings to ensure the practice improved outcomes for patients.