Castle 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?	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 visited Castle Street Surgery on the 10 November 2014 and carried out a comprehensive inspection.

The overall rating for this practice is good. However, there are some areas where improvement could be considered.

Our key findings were as follows:

- Patients were satisfied with the service they received. They reported they were treated with dignity and respect and that they were not hurried during their consultation.
- The practice had a good approach to ensuring that clinical care was up to date and in line with national guidance and carried out audit to determine the effectiveness of care.
- There was an ethos of openness and honesty and staff reported feeling supported in their role.
- The practice engaged well with the local clinical commissioning group to develop services and address the health needs of the practice population.
- The practice had developed links with the local university to identify whether there were any young people who were suffering with anxiety or depression and who may have needed extra support.

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

The provider should:

- Develop a business strategy to manage risk and identify what action they would take if business continuity was compromised. This should specifically include risks regarding new premises proposed for next year and what they would do if the premises were not funded or built in time.
- Introduce a more robust system to ensure that all staff are aware of lessons learnt from incidents, complaints and events that take place in the practice. There should be a regular meeting with all staff both clinical and administrative to facilitate this.
- Carry out an audit of infection control and ensure that a process is introduced to ensure that monitoring of infection control takes place.

Summary of findings

- Ensure that the extended hours appointments are advertised in the practice leaflet and the website.

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. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated to support improvement although the system of sharing this could be more robust. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. Peoples' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained 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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP with urgent appointments available the same day.

Summary of findings

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. There was evidence of learning from complaints and responding in a timely manner.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) had recently formed and was establishing. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people and offered home visits, over 75 health checks and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that 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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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. They had established links with the local university to identify

any students who were suffering from anxiety or depression and who may have needed additional support. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for these patients. Longer appointments were also offered to those patients who required an interpreter.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with five patients and reviewed 18 comments cards which patients had left. All patients we spoke with expressed satisfaction with the service. They commented on always being able to see a doctor if they needed one urgently. Three patients expressed that their long-term health conditions were managed well and were reviewed at appropriate intervals.

All patients we spoke with told us that the doctors and nurses explained their conditions and that they felt involved in their treatment decisions. One patient we spoke with expressed that although they were satisfied with care and treatment overall, they did sometimes find it difficult to get through on the telephone for an appointment. This was also noted on four comment cards we saw.

Of the 18 comment cards, the majority reported receiving good care from the practice stating that they were treated with respect and that doctors and nurses were caring. They commented that they were not rushed during their consultation with clinicians who took time to explain their condition and treatment.

Areas for improvement

Action the service SHOULD take to improve

- The practice should develop a business strategy to manage risk and identify what action they would take if business continuity was compromised. This should specifically include risks regarding the new premises proposed for next year and what they would do if the premises were not funded or completed in time.
- The practice should introduce a more robust system to ensure that all staff are aware of lessons learnt from incidents and events that take place in the practice. There should be a regular meeting with all staff both clinical and administrative to facilitate this.
- There had been no assessment or audit of hygiene and cleanliness at the surgery. The practice need to implement a process to ensure monitoring of infection control takes place.
- Advertise the extended opening hours on the website and include them in the practice leaflet.

Castle Street 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, another CQC inspector and a specialist advisor in practice management.

Background to Castle Street Surgery

Castle Street Surgery is situated in the central area of Luton and provides general medical services to a practice population of approximately 10,500. The practice has an above average number of patients in the 20-39 age groups and provides services to a significant number of students at the local university. There are four GPs, four practice nurses, a health care assistant, phlebotomist, practice manager and a number of reception and administrative staff.

The practice have a General Medical Services (GMS) contract and have performed consistently over time delivering local and directed enhanced services and have participated in the Quality and Outcomes Framework to drive quality in patient care.

The practice service for out of hours care is via the NHS 111 service.

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.

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 peoples' 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. These groups are:

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

Detailed findings

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We spoke with the local Clinical Commissioning Group (CCG), the Local Medical Committee (LMC) and NHS England.

We carried out an announced visit on 10 November 2014. During our visit, we spoke with a range of staff including GPs, nurses, the practice manager, reception and administrative staff and spoke with patients who used the service. We observed how staff dealt with people who attended the practice and looked at staff records and policies and procedure showing how the practice managed specific issues in the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as 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. For example, GPs told us that the practice manager emailed safety alerts to all staff and a paper copy was stamped and circulated to the clinical team. These were also discussed at practice meetings and verbally between clinicians. One nurse gave an example of a recent incident regarding prescribing which had raised an awareness of the need to ensure the patients understanding of their medication. We saw evidence that this had been shared with the team.

We reviewed incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time 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 saw evidence of some recorded significant events that had occurred during this year. Staff we spoke with gave clear examples of significant events and how they had been investigated and shared with other clinicians throughout the practice. However, there was no clear process to ensure that all staff were aware of the outcomes and learning from events as outcomes were often shared verbally.

The practice held significant event and clinical governance meetings six monthly and we saw the minutes of the last meeting. Nurses we spoke with told us that they did not attend this meeting unless there was a specific event relating to them. We saw from the minutes that only GPs and the practice manager attended. There was evidence that the practice had learned from these and staff reported that they could see the findings if they wished on the practice shared drive. The introduction of a more robust process for logging and sharing the outcomes of significant events would ensure that learning was shared with every member of staff.

National patient safety alerts were disseminated by the practice manager via email to all practice staff and a hard copy was stamped. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, such as prescribing alerts. They also told us alerts were discussed at practice meetings and verbally between clinicians to ensure all staff were aware of any alerts 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. A member of staff was dedicated to updating relevant policies and we saw that the safeguarding policy and procedures had been updated in June 2013. The policy relating to keeping peoples' records safe had been updated prior to our inspection. All policies, including those relating to peoples' safety, were accessible to all staff on the practice's computer system. We saw that hard copies were also available in the administration office.

We asked members of the medical, nursing and administrative staff about their most recent safeguarding training and we saw certificates from June 2013 that showed that staff had attended relevant training at the local hospital trust. Staff had also received online refresher training in safeguarding through the course of the summer of 2014.

There was a designated lead clinician for safeguarding who had received Level 3 training in safeguarding children. They had responsibility for participating in the local authority multi-agency safeguarding procedures in relation to children or vulnerable adults who might be at risk. The lead clinician also reviewed particular patients known to be at risk during regular meetings with the practice nurses. The practice manager was the identified Caldicott Guardian, a person who is responsible for ensuring information about patients is kept safe and only shared when necessary.

There was a system to highlight vulnerable patients on the practice's computer system. Staff we spoke with told us that this included information on specific issues so they were aware of any relevant background when patients attended appointments. For example, children who were the subject of a child protection plan.

Good

Are services safe?

Our discussions with staff showed that they were aware of the roles of the designated lead staff and understood what their own role was in keeping people safe. We found that staff knew how to recognise signs of abuse in older people, vulnerable adults and children and would respond effectively. For example, we learned of an incident which had resulted in concerns about a young patient being escalated to the lead GP and referred onwards through the local authority's procedures.

The practice was 'paperless' in that every patient's records were held electronically on a system that was only accessible through a secure log-in. Older paper records that were archived were held securely in a separate room.

Medicines management

We found that the practice operated a safe prescribing and repeat prescribing process and that the policies on these were updated annually. Repeat prescriptions could be ordered through the practice or through the pharmacy close by. The practice had also recently begun to use an electronic prescription service where patients cold request repeat medicine online. The designated staff members who were responsible for managing the repeat prescription process had received detailed instructions on how to carry out their role.

The practice followed a standard repeat prescription timescale of 'within 48 hours'. Feedback we received from patients about their prescriptions was good. Patients reported that they experienced no delays in obtaining their medicines and that they always received the medicines they needed.

All prescriptions were reviewed and signed by a GP before they were issued to a patient and were held in a collection box in the reception. Staff told us that the collection box was checked regularly to ensure no older items had been left there and that any uncollected items were then followed up with the patients. We checked the collection box and saw that this was the case.

Blank prescription forms were tracked through a record keeping system and were held securely in a locked cabinet at all times.

We found that all medicines stored at the practice, including vaccines and emergency medicines were managed and stored safely. This included effective arrangements for ordering and checking stocks of medicines which was carried out by a designated member of staff.

Medicines stored in the treatment rooms and refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring temperature-sensitive medicines were kept at the required temperatures from the time they were received, to the time they were used. This was being followed by the practice staff who understood the importance of maintaining these temperatures. We noted that there was clear process for monitoring fridge temperatures daily and for rotating medicines in the fridge to ensure they were used in date order.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked, including those intended for emergency use, were within their expiry dates. Expired and unwanted medicines were returned to the pharmacy for disposal.

The practice did not hold any stocks of controlled drugs.

Cleanliness and infection control

We saw that the premises were clean and tidy. Treatment rooms were cleaned and maintained appropriately to ensure they remained hygienic. For example, we saw that examination curtains had been replaced in November 2014. We saw there were cleaning schedules in place with a list of areas that needed cleaning daily, weekly and monthly. However, we spoke with the practice manager and the designated staff member for infection control and found there were no records kept to help the practice to monitor the effectiveness of the cleaning process.

Clinical waste and bins containing used sharp instruments were securely stored outside the premises and were collected weekly by the local council. We saw that mops used for different purposes within the practice were stored haphazardly with no clear separation between them. This increased the risk of contamination.

An infection control policy and supporting procedures were available for staff to refer to and these had been updated in line with the practice's annual review of policies. This enabled staff to implement effective control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were

available for staff to use and staff were able to describe how they would use these. There was clear information about hand-washing at all the sinks as well as appropriate gel and towel dispensers. There was also a protocol to be followed in the event of anyone suffering a 'needle-stick' injury.

We noted that the practice had a safe system for handling blood and other samples using a red 'drop-box' at reception and an accompanying protocol to ensure samples were not handled and did not come into contact with other surfaces. We saw that staff understood the protocol and had a general insight into the risk of contamination.

The practice had a lead for infection control who had undertaken recent further training to enable them to provide advice on the practice infection control policy and to provide additional staff training, for example, to new staff members. The induction programme for new staff contained a comprehensive section on infection control. We saw that all staff had received an annual infection control training update which was completed online.

The lead member of staff for infection control had only recently been delegated with this role and so we discussed in detail their plans for ensuring heightened awareness among staff and for compliance with proper processes. The staff member acknowledged that there had been no infection control assessment or audit carried out by the practice prior to their appointment although a blank self-assessment tool was in place ready to be used. There had been no other checks on the effectiveness of infection control procedures that had taken place to that point. For example, there was no hand-washing audit or formal monitoring of the effectiveness of the cleaning schedule. We were assured that an infection control audit would take place as a priority.

Staff were aware of the risks of acquiring a healthcare associated infection, had received training and were supported by updated policies. However, implementation of an infection control audit process and the introduction of a process to monitor the cleaning of the premises identifying daily, weekly and monthly tasks would ensure that the risk of healthcare associated infection was reduced.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was well equipped with adequate stocks of equipment and single-use items required for a variety of clinics, such as the asthma clinic and procedures, such as minor surgery.

Staff told us that all equipment was tested annually and maintained regularly and we saw records that confirmed this. All portable electrical equipment was routinely tested by an independent company and displayed stickers indicating the last testing date. We saw that relevant equipment such as blood pressure monitors, a spirometer (for measuring lung functions) and an electro-cardio gram (ECG) machine were regularly calibrated to ensure they were operating safely and effectively.

Staffing and recruitment

We looked at the recruitment policy and staff records. We looked at three staff files and found evidence that appropriate recruitment checks had been undertaken prior to people being employed. These included proof of identification, references, qualifications, registration with the appropriate clinical professional body and, if applicable, criminal records checks through the Disclosure and Barring Service (DBS).

The practice manager talked us through the arrangements for planning and monitoring the numbers and skill mix of staff needed to meet patients' needs. This was based on the anticipated number of sessions needed for the patient population and was estimated using a formula derived from the patient records system. We noted that, for example, arrangements had been made to recruit another member of nursing staff in advance of changes to the amount of sessions covered by the current nursing team. We saw there was a rota system in place for all the different staffing groups to ensure they were enough staff on duty and this was set six to eight weeks in advance. There was also a system in place that ensured staff members could cover each other's absence.

Monitoring safety and responding to risk

We saw that the practice had procedures in place to deal with potential medical emergencies including an emergency button on each computer terminal to alert staff

to the need for urgent assistance. We learned of occasions when this had been used including a recent incident where a patient had been taken ill suddenly in one of the treatment rooms.

All staff had received training in basic life support and received update training annually. This included a training drill on responding to patients suffering anaphylactic shock associated with an allergic reaction to vaccines. We noted that there were anaphylaxis kits containing appropriate medicines in each treatment room so they could be identified easily in an emergency.

The practice held an automated external defibrillator (AED), a device used to restart the heart in a medical emergency, as well as emergency oxygen. The AED and the oxygen were stored in a location that all the staff could access quickly when required. The practice carried a stock of medicines for use in the event of a medical emergency. These included medicines for use for people experiencing chest pain or a diabetic emergency. The emergency medicines, including those used in the anaphylaxis kits were checked weekly to ensure they were within their expiry dates.

We heard from staff at all levels that they felt able to share immediate concerns about risks to individual patients with a clinician. Staff told us they felt confident they could recognise patients who might have acute clinical needs requiring a clinician's input as a priority and would ensure they were seen immediately.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The document was kept under review and hard copies were located both on and off-site. The document indicated that it had last been reviewed in January 2014 and was due for review in January 2015. It contained sufficient relevant information to enable the practice to function in an emergency. However, we found out of date references to contact with the Primary Care Trust in relation to continuity of care where these should have referred to the Clinical Commissioning Group and NHS England. This indicated that the plan had not been reviewed in the level of detail that it might have been and could result in delays in establishing the relevant local contacts during a major adverse event.

The practice was undergoing negotiations to relocate to a brand new building very close by. This new building was unfinished, but nearing the end of construction at the time of our inspection visit. We learned that the proposed occupation of some of the building by the practice was seen as essential by the partners and the management team due to significant shortfalls in the standard of the building in which the practice was currently situated. We also learned that the practice was not completely certain that the proposed move would take place as they were waiting for assurances from elsewhere in relation to funding. We found that there was no formal means of identifying and managing either the risks to the practice arising from the condition of the building they currently occupied or the risks to the project for occupying the new building.

We were shown the notes of four partners' meetings that had taken place through the summer and noted that the proposed move had been discussed. However, the notes of these discussions were superficial and did not identify specific issues or risks, the impact on patients or the practice, the means of managing the risks or tracking their progress. We discussed the absence of a risk log or any other means of managing such risks at such a critical time with the practice manager and one of the partners who acknowledged this shortfall.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For example, the GPs gave examples of information received from the Department of Health and the nurse gave examples of local microbiology guidelines recently implemented.

The practice had identified GP leads for each chronic disease area, for example, asthma and diabetes who ensured that any new guidance was addressed and templates and practice protocols were changed or adjusted appropriately. The GPs told us that new guidelines were disseminated and discussed at practice meetings as well as verbally in the practice.

The GPs and nurses told us that the practice engaged well with the local clinical commissioning group (CCG) having two GPs who sat on the CCG committee. They reported information to the practice to ensure that staff were aware of current issues to health care.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when necessary. We saw evidence from nurse meetings that plans had been made to review certain protocols in response to change in recommendations, for example the chronic obstructive pulmonary disease protocol.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, nurses told us that they have meetings with one of the GPs who recently provided an update on Ebola and advised on the actions to take. The nurses told us they received opportunities to keep up to date, for example, protected learning days every other month where they met with nurses from other practices and also had teaching sessions on topics such as gynaecological conditions.

The GPs showed us that they were using risk stratification to identify 2% of patients at risk of admission to hospital, which included patients from care homes, those under the care of the community matron and those suffering with chronic obstructive pulmonary disease (COPD). They showed us their plans regarding how they were going to manage this group of patients.

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. We spoke with clinical staff who demonstrated that they supported people to make informed choices and consent. They demonstrated knowledge of and commitment to ensure Gillick competence when necessary. Gillick competence refers to a child under 16 who is able to demonstrate they are capable of making decisions and giving consent without parental consent.

Management, monitoring and improving outcomes for people

We saw evidence of two clinical audits. For example, there was minor surgery audit where a review had brought about a change in practice and the practice had developed a new protocol in response to this. We also saw an audit regarding patients using a specific medication demonstrating a full audit cycle where changes had been implemented and revisited to confirm whether they had been effective. A full audit cycle is one that includes revisiting actions at a later date to determine whether they have been effective.

The GPs we spoke with told us that audit was shared at their partners' meetings held monthly. Nurses we spoke with also told us that they were kept informed of changes and updated regularly but that this was generally verbal, as they did not attend management meetings. We saw evidence of nurse meetings where the lead GP for nurses attended and reported on current issues. We noted that from discussions with the practice manager that the management and partners meetings were not always minuted meetings but were shared by means of verbal discussions with all GPs and nurses where necessary. The practice manager showed us evidence of the topics discussed and some minutes. However, as not all of the GPs were always available every week the practice manager would meet with one GP and the points would be feedback to the other GPs. The practice should consider

Good

Are services effective?

(for example, treatment is effective)

introducing a more systematic approach to sharing information to enable them to revisit issues and assure themselves they have been dealt with appropriately and that all staff were aware.

The practice had lead roles for a variety of areas to ensure that outcomes and patient care was continually monitored and improved. Staff across the practice had key roles in monitoring and improving outcomes for patients. For example chronic obstructive pulmonary disease, cancer and heart disease. Their roles included ensuring that the recommended guidance was followed and patients received the appropriate treatments.

The practice also used the information collected for the Quality and Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The practice had a high achievement in all areas of the QOF clinical targets, for example, diabetes, COPD, asthma.

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, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area and were not outliers in any area. For example, they had systems in place to address all areas of chronic disease management, such as heart disease and hypertension and patients were receiving annual reviews in a timely manner. The practice had adopted a systematic approach to chronic disease management and had identified patients with multiple chronic conditions and ensured that they received a review of all their conditions at one consultation. This promoted a more holistic delivery of care and reduced the number of patients who did not attend.

All patients over 75 were offered health checks and patients with severe mental health needs had a named GP. Patients with learning difficulties received annual health checks and had care plans, which had been agreed with them.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We saw an up to date recruitment policy and a recruitment checklist, which contained an outline of induction for a new member of staff.

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

We saw evidence of staff annual appraisals that identified learning needs from which action plans were documented. Both nursing staff and administrative staff we spoke with told us that they felt they were given good opportunities for development. For example, training in diabetic foot management. Staff also told us they had access to online training with a range of subjects available for development including mandatory training such as cardio pulmonary resuscitation.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. The practice had a lead nurse for cervical screening and family planning and sexual health and had received specialist training in these areas. They were able to describe the service they offered for example, cervical cytology and insertion of contraceptive implants and a range of advice and support to patients in this area of care.

Working with colleagues and other services

The practice worked with other service providers to meet peoples' needs and manage complex cases. It received

Good

Are services effective?

(for example, treatment is effective)

blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice had taken up the new enhanced service and were identifying patients at high risk of unplanned admission to hospital. They were planning to review all patients who had been admitted and review them to help prevent unnecessary future admissions. They were also coding patients who had been to A&E from the hospital discharge letters (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called SystmOne to coordinate, document and manage patient care. We spoke with nurses and GPs who were trained to use 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.

The practice also used Choose and Book for making referrals to secondary care. (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). Staff reported that this system was easy to use.

During our inspection, we noted that the practice had also developed links with the local university to identify whether there were any young people who were suffering with anxiety or depression and who may have needed extra support. The practice nurse also attended meetings with the local diabetes specialist nurse and shared information to develop better care for patients suffering with diabetes.

The practice nurse told us that they had good links with the local council, which enabled them to compare registers of patients with learning disabilities to ensure that they reflect accurately patients who required additional support.

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. Clinical staff were able to give several examples where they had assessed the capacity of patients to give consent and demonstrated the appropriate actions to deal with this in line with best practice.

They were able to describe how patients should be supported to make their own decisions and how these should be documented in the medical record. We saw evidence of formal written consent forms for procedures such as minor surgery and the nurse we spoke with confirmed the need to document that verbal consent had been sought.

Patients with a learning disability and those with dementia were supported to make decisions using care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

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 and prevention

The practice offered all new patients a health check which was carried out by the health care assistant. Staff told us that any patients who needed to see a GP following this check would be advised accordingly and booked an appointment.

Nurses we spoke with told us that they would always carry out opportunistic health promotion if patients had attended the surgery for a procedure. For example, if a patient had attended for a cervical smear they would discuss sexual health during this consultation if appropriate, or enquire regarding smoking status and whether smoking cessation support was required.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75. Any issues noted from these checks were referred to the GP for treatment and further and investigation. Staff provided an example of when a patient had been referred immediately to the GP following a health check where they needed immediate support and treatment and had been referred to another agency specialist help.

The practice had numerous ways of identifying patients who needed additional support and was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all patients were offered an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and offered nurse-led smoking cessation clinics to these patients. They provided telephone smoking cessation advice and were able to give examples of patients who had achieved two-year cessation success.

Cervical smears were offered to women in line with the national guidance and the nurse offered advice on chlamydia screening and sexual health to young women who sought contraceptive products. There was a named nurse responsible all cervical screening and who carried out audit on all nurses carrying out smear tests. The practice nurse told us that housebound patients had their smear test taken in the home following appropriate consent. Patients who required insertion of coils were counselled by the practice nurse and signposted to the local community sexual health clinic and those under 25 years were directed to the Brook Clinic, which was an age specific local contraceptive and sexual health service.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for immunisations in the first year was above average for the CCG.

The Living Well team attended the practice on a Tuesday and patients who had a BMI of over 30 would be referred for help with weight management if they wanted it. The practice also had an alcohol link worker who the GP could signpost to if a patient presented with alcohol issues.

The practice nurse told us that the practice had a co-ordinated approach for patient with multiple long-term conditions. This enabled them to attend for one appointment and have a review of all their conditions at one time to prevent inconvenience to patients and encourage better uptake of chronic disease management.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection, we spoke with six patients who told us that they were satisfied with how they were treated at the practice. They told us that staff treated them with respect and that the doctors and nurses listened to their problems and they were not hurried during their consultation. Some patients remarked that the doctor ran late at times, but commented that this was because they did not rush patients.

Patients reported that reception staff were polite and helpful. During our inspection, we noted that the staff were respectful and assisted the patients to book appointments.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. There were some comments which were less positive regarding ease of getting an appointment. Patients we spoke with told us that they could always get an appointment although it may not have been with the GP of their choice. All patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

The reception area was open and we observed that generally patients stood back when other patients were speaking with the receptionist and the main waiting area was set back from the reception area.

We noted a sign advising to patients that they could speak with the reception staff in a private room if they needed to talk in confidence.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

Patients we spoke to in the practice told us that both GPs and nurses involved them in their care and treatment. They told us that they always received information regarding their condition and that any medication was explained to them before they left the surgery. The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 91% of practice respondents said the nurse was good at listening to them compared to 80% nationally and 82% reported that the GP involved them in decisions regarding their care compared to 75% nationally.

Comments were noted regarding patients receiving clear explanations and options of treatment from their GP and that they had been notified by the practice that tests were due. Two other patients commented on their satisfaction of how their long-term condition had been managed. Staff told us that translation services were available for patients who did not have English as a first language and explained the process for this. They also offered longer appointments for patients requiring an interpreter. Reception staff told us that patients often expressed a wish to have a family member to interpret and if this was the case then the patient's wishes were respected.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us that the GPs and nurses gave them time to ask questions and understand their care and treatment. We heard examples from patients who had suffered bereavement where the GP had contacted them to offer additional support and they reported that they had found

Good

Are services caring?

this very helpful. Staff told us that when families had suffered bereavement, their usual GP contacted them. This call was followed either by a patient consultation or by giving them advice on how to find a support service.

Notices in the patient waiting room and the website also told people how to access a number of support groups and organisations. For example, a notice board providing information to carers, together with handbooks from the local carers association.

The comment cards we received also highlighted that staff responded compassionately when they needed help and provided support when required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting peoples' needs

We found the practice was responsive to peoples' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had a high number of students registered with the practice and had established links with the local university to identify any patients who needed support. They also had access to a local counselling service to offer support to patients suffering from anxiety and depression. The practice had identified issues with patients experiencing difficulty getting appointments and had responded by setting up a triage system to enable more urgent cases to be dealt with appropriately.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from Healthwatch England. For example, they had recently visited and suggested the need for a hearing loop to assist those patients with hearing difficulties. We saw that this had been installed in the reception area. Healthwatch England is the national consumer champion in health and care. They ensure the voice of patients is strengthened and heard by those who commission, deliver and regulate health care services.

We did not see any changes in response to the patient participation group (PPG) as it had only recently been set up and they only recently had their first meeting. However, the practice explained that they had experienced difficulty for a considerable time in establishing a PPG and they intended to work with them to develop.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of services. The premises and services had been adapted to meet the needs of people with disabilities. We saw that there was wheelchair access at the side of the building and this was advertised on the practice website.

Consulting rooms were situated on the ground floor of the building. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toilet facilities were available for all patients.

The practice provided longer appointments for patients with learning disabilities and those whose first language was not English and who needed an interpreter. The practice had access to translation services and they had a receptionist who spoke Asian languages. They offered a full service to students from the local university and provided a range of appointment options such as online, telephone and bookable at the surgery.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training. There were also female doctors available for patients who had a preference of gender.

Access to the service

Appointments were available from 8.30 am to 6.30 pm on weekdays. The practice also offered extended opening hours appointments on different evenings of the week from 6.30pm until 8pm. Whilst the general opening times were advertised in the practice leaflet and on the website, there was no advertisement of the availability of extended hours appointments. Inclusion of this information on the website and in the practice leaflet would reach a wider range of the practice population and provide patients with more choice. The extended hours appointments were specifically aimed at people who worked and students who could not access the practice during the day.

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

Longer appointments were also available for people who needed them and those with long-term conditions and

Good

Are services responsive to people's needs?

(for example, to feedback?)

severe mental health problems. The practice had provided home visits to patients in local care homes when necessary although the practice had a much lower than average number of elderly patients.

Patients were generally satisfied with the appointments system. 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 their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, two patients we spoke with during our inspection had called that morning for an urgent appointment.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system which was set out in the practice leaflet. We saw that there was a complaints file and that outcomes of complaints were discussed at the clinical governance and significant event meeting. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. There was evidence that the practice had responded to complaints regarding access to appointments and had introduced a new telephone triage system to address this.

We looked at evidence of four complaints received in the last 12 months and found that they had been addressed appropriately and dealt with in a timely way. Whilst the complaints had been discussed with the GPs there was no robust process in place for sharing outcomes of complaints with all staff. Staff we spoke with told us that they are aware of everything that takes place in the practice verbally but that this was not discussed at a formal meeting. They told us that they use a daily book to share information and that all staff used this. There was no way of evidencing that all staff had read this. The practice should ensure that all learning from complaints is shared in a way that can assure themselves all staff have been made aware of the outcomes.

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

GPs at the practice told us that there had been major changes to the structure of the practice in recent months. This had provided an opportunity to review how the practice functioned and moved forward. All the staff and partners demonstrated commitment to developing the practice with agreed values and clear vision to deliver high quality care and promote good outcomes for patients. Staff we spoke with confirmed that they felt involved in the practice and that providing good primary care and ensuring that patients' needs were met was the focus. All staff expressed that they felt the practice was flexible, open and honest and was continually working together to address the needs of the practice population.

Following discussion with the GPs, we found that the practice was due to relocate in 2015 and this had taken up considerable time in planning. A new premises was being built in close proximity to the current surgery which is due to be condemned. The practice have had numerous discussions with local organisations and commissioners regarding the new building and have a clear vision for the future. However, there was no clear management plan which identified and addressed risk should the building not be completed or funding secured. The practice should develop a risk log to highlight risks and how they intend to deal with them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. There was a member of staff responsible for updating the policies and ensuring that staff were aware of any changes. The member of staff responsible showed us the process for ensuring staff were aware and signing that they had seen them.

There was a clear leadership structure with named members of staff in lead roles. For example, there had recently been a nurse nominated as lead nurse for infection control and the senior partner was the lead for safeguarding. The GPs also had identified areas of responsibility, such as health and safety, and human resources. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) data to measure its 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 actions identified to maintain or improve outcomes. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.

The practice engaged well with the CCG and the GPs told us about a local peer review system they took part in with neighbouring GP practices. This involved areas such as comparing outpatient referrals to determine their appropriateness.

The practice had carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, prescribing specific medications and prevention of osteoporosis.

Discussions with GPs showed that the practice were aware of their vision and had plans to achieve this. However, the practice could not demonstrate formal robust arrangements for identifying, recording and managing risks. There was no risk log available to show that these had been identified and mitigated. This is an area which the practice should address to ensure that when changes to the practice site are underway all areas have been examined to eliminate unnecessary risks. This should identify mechanisms to protect patients from any risk of gaps in service delivery. We saw that partners meetings took place and the plan for the surgery move was discussed but there was no evidence of addressing risk.

The practice held governance meetings and significant event meetings every six months and we saw a schedule of meetings which took place in the practice. We looked at minutes from the last meetings and found that performance and quality had been discussed.

Leadership, openness and transparency

Staff we spoke with expressed that they felt the practice was open and transparent in their approach to all issues and felt involved in what took happened. The practice nurses told us that they had a designated GP who attended

Are services well-led?

Good

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

their meetings which took place every three months. We saw from minutes those meetings which showed attendance from all the nursing team. Staff told us that they attended the monthly protected learning session and had opportunity to share experiences and information with staff from other practices.

There was a lead GP responsible for human resources (HR) and the HR policies and procedures were updated and maintained by a member of the administration staff. We reviewed a number of policies, for example, the induction policy and recruitment policy which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

The practice had recently undertaken training to determine personality and leadership traits to help them understand how to gain the best from the skills in the team. The GPs told us that they intended to explore new ways of working and develop the practice in view of the new building with better facilities being available soon.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and 69% of patients commented that their experience making an appointment was good. They had also received feedback that it was difficult to get through on the phone to get appointments. The practice had installed a new number to make it easier to direct the patient to the appropriate person. They had also implemented a triage system which had been established with involvement from the nursing staff. The nursing staff had been able to share comments from patients to identify that this was an issue. We saw as a result of this the practice had introduced telephone consultation appointments.

The practice had a patient participation group (PPG) which had recently formed and had approximately 15 patients participating. We did not speak with a representative during our inspection, as they were a newly formed group and had only recently held their first meeting which the practice manager had attended.

Staff told us they felt their opinions were valued and would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with confirmed that they were aware of this.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that appraisals took place and there was appraisal documentation which included a personal development plan and details of mandatory training. Staff told us that the practice was supportive of training and that they felt they were supported to attend any training they identified which would enhance their role.

The practice was a GP training practice and the practice accommodated medical students and trainee GPs who worked under the supervision of the GPs. However, there were no students or trainees present during our inspection. The practice website and information leaflet informed patients that students were sometimes in attendance and advised patients to notify reception if they did not wish to have a student present during their consultation.

Following conversations with clinical staff it was clear that they did receive information of the outcomes of significant events and complaints. However, there was no clear process for ensuring that all staff had been made aware. The practice should introduce more robust mechanisms to ensure information is shared with all staff.