Lister House Surgery

Quality Report

Lister House Surgery
The Common
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Date of inspection visit: 24 June 2015
Date of publication: 17/09/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lister House Surgery on 24 June 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 good for providing services for older people, people with long term conditions, families with young children, working age people, those whose circumstances make them vulnerable and those suffering with mental health problems.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Care plans were used for patients with long term conditions and those with poor mental health.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had responded to feedback from patients when planning its services.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

Summary of findings

- Lister House had been accredited as a Purple Star practice in May 2015 and was the first practice to receive this. Purple Star was a local initiative hosted by Hertfordshire county council that promoted health equality for people with learning disabilities.

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. Significant events was a standing item on the weekly partners' meeting and the quarterly staff meeting agendas so lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients 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 the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Patients with long term conditions were receiving regular health checks. The practice was working well with other services including the community matron and local care homes. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and 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 comparably with others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Patients commented on how professional and helpful all levels of staff were.

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found that urgent appointments were available the same day. The practice had responded to feedback and

Summary of findings

changed its premium rate telephone number to a local rate one and increased the availability of staff to answer the telephones at peak times. 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. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision. 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. 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. 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. They visited the residents of six local care homes. Each home had a named GP who visited weekly. It was responsive to the needs of older people, and offered home visits 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. 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. They worked with the community matron who completed health checks for housebound patients with long term conditions. 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. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice nurses were trained to give contraceptive advice and insert contraceptive devices. We saw good examples of joint working with midwives and health visitors.

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

Summary of findings

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 reflects the needs for this age group. Extended opening hours were available one evening and one morning a week to allow patients in work to attend the practice. They also opened one Saturday morning a month.

People whose circumstances may make them vulnerable

Outstanding ☆

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 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

Lister House had been accredited as a Purple Star practice in May 2015 and was the first practice to receive this. Purple Star was a local initiative hosted by Hertfordshire county council that promoted health equality for people with learning disabilities.

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). 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 and other mental health conditions.

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

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and they were all positive about the service experienced. Patients said they felt the practice offered a very good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three of the cards in addition to the positive comments had remarks about the appointment system and how it is sometimes difficult to get an appointment with the GP of choice. There was one negative comment about a GP however there were many positive comments about how professional and helpful all levels of staff were.

We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Data from the national patient survey 2014 showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated comparably with others nationally for patients who rated the practice as good or very good.

Outstanding practice

- Lister House had been accredited as a Purple Star practice in May 2015 and was the first practice to receive this. Purple Star was a local initiative hosted by Hertfordshire county council that promoted health equality for people with learning disabilities.

Lister House 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 another CQC inspector and a GP acting as a specialist advisor.

Background to Lister House Surgery

Lister House Surgery provides a range of primary medical services to the residents of Hatfield, southern Welwyn Garden City and parts of St Albans.

The practice population is of mixed ethnic background and national data indicates that the area is one of lower deprivation. The practice has approximately 12,300 patients and provides services under a general medical services contract (GMS).

There are seven GP partners who run the practice, three male and four female. The nursing team consists of one nurse practitioner and one practice nurse. There are a number of reception and administration staff led by a practice manager.

The practice is open between 8am and 6.30pm Monday to Friday and offers extended opening on Monday evenings until 7.30pm and on Thursday mornings from 7am. It also opens on the last Saturday each month.

When the practice is closed out-of- hours services are provided by Herts Urgent Care and can be accessed via NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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 (Regulated Activities) Regulations 2014, 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 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

Detailed findings

- 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 24 June 2015. During our visit we spoke with a range of staff including the practice manager, GPs, nurses, reception and administration staff. We spoke with patients who used the service and we observed how people were dealt with by staff during their visit to the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. They informed us that incidents and near misses were reported to the practice manager or in their absence to a nominated GP. We saw a recent incident that had been documented regarding a missed referral and an action plan that had been put in place following the investigation.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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 reviewed records of eight significant events that had occurred during the last 18 months and saw this system was followed appropriately. Significant events was a standing item on the weekly partners' meeting and the quarterly staff meeting agendas. A dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Electronic incident forms were available on the practice's computer system and sent to the practice manager when completed. We tracked six incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example we saw an incident where a patient had been given wrong information regarding their test results. Once identified the incident was logged and investigated and the patient contacted and given the correct information and an apology. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to practice staff. Alerts received were in relation to medications, medical devices and disease outbreaks. Alerts were discussed at practice meetings and copies kept on the practice computer system. Staff we spoke with gave an example of a recent alert received which resulted in the practice completing an audit of patients receiving a combination of two medications.

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 most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. The treatment rooms contained flow-charts giving guidance on the steps to take when a safeguarding concern had been identified. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the leads was and who to speak with in the practice if they had a safeguarding concern. One of the practice nurses gave us an example of a safeguarding concern they had identified and the steps taken to make an appropriate referral to the relevant organisations.

The clinical staff used codes on the practice's electronic records to highlight vulnerable patients. 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 active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff had been trained to be a chaperone. Reception staff had also undertaken the training but were not performing the role as they had not received a Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice manager informed us they were going to complete a risk assessment to demonstrate the reception staff members would never be left alone with a patient.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a policy in place for repeat prescribing that had been reviewed in April 2015. All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were up to date. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. One of the nurses was qualified as an independent prescriber. They received regular supervision and support as well as updates from one of the GPs.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had an infection control policy and supporting procedures. These were available for staff to refer to, which enabled them to plan and implement measures to control infection. 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 to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We also saw the practice had spillage kits to use to clean up bodily fluids.

A GP and a nurse were identified as the leads for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that

infection control audits had been carried out and that any improvements identified for action were completed. For example fabric chairs had been re-covered with wipeable surfaces.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella, a bacterium which can contaminate water systems in buildings. We saw records that confirmed the practice had done a risk assessment and was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was March 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. These had all been calibrated in April 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at four staff files and found they 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 the appropriate DBS checks.

There were arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Many of the staff worked part-time and would work extra hours if needed. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice manager informed us that staff roles are constantly reviewed and developed so staff can take on additional responsibilities.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service were included on the log, for example fire risk assessment and legionella assessment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Panic buttons were available in all the consulting rooms so staff could alert others and gain help quickly in the event of an emergency. When we asked members of staff, they all knew the location of the emergency equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff 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. 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.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in 2011 that included actions required to maintain fire safety. The fire alarms and fire equipment were checked regularly and had been done in April 2015. Records showed that staff were up to date with fire training with further training planned for all staff in September 2015. They practised regular fire drills. The last drill had taken place in December 2014.

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 the local clinical commissioning group (CCG). We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The clinical staff we spoke with described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required.

The GPs told us they lead in specialist clinical areas such as diabetes, dermatology and prescribing. The practice nurses were trained to support the GPs and look after patients with long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GPs provided clinical support and appraisals for the nursing staff. There was a buddy system in operation for GPs to cover for each other and review communications if one was on leave.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. All staff had received equality and diversity training.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us eight clinical audits that had been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example an audit had been completed to see if patients following a certain type of surgery received appropriate vaccinations as recommended in national guidelines. As a result of the audit an increase in the number of patients receiving the vaccinations had been documented. Another example showed patients who were diagnosed with gestational diabetes, a type of diabetes that affects women during pregnancy, were recalled to the surgery six weeks after delivery for investigations to see if they continued to have diabetes.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. For example, we saw an audit regarding the prescribing of a combination of a particular anti-depressant and a medication to reduce stomach acid. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and changed either or both of the medications to alternatives.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This

Good

Are services effective?

(for example, treatment is effective)

practice was not an outlier for any QOF (or other national) clinical targets, It achieved 93% of the total QOF target in 2014, which was comparable to the national average of 94%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- Performance for mental health related and hypertension QOF indicators was similar to the national average.
- The dementia diagnosis rate was comparable to the national average

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. A prescription could only be issued if a review had been done. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and held regular internal meetings as well as multidisciplinary meetings every three months to discuss the care and support needs of patients and their families. The administration staff had a palliative care pack that included a check list of things to do when a patient was on the register. The practice worked with a local hospice to ensure palliative care needs were met and had an identified palliative care nurse from the hospice they liaised with to discuss new referrals and concerns about patients.

Lister House had been accredited as a Purple Star practice in May 2015 and was the first practice to receive this. Purple Star was a local initiative that promoted health equality for people with learning disabilities. It was awarded to services following staff participation in specialist training, service checks and monitoring to ensure the standards were met. The specialist training would incorporate improving health care for people with a learning disabilities, including what provisions could be made for adults with a learning disability, in particular, promoting the provision of reasonable adjustments.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups this included patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions for example diabetes, COPD and heart failure.

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. For example A&E attendances, prescribing data and consultant referrals were all average for the CCG locality.

One of the GPs was the locality and practice CCG lead. They attended meetings monthly with representatives from nine other local practices. Information from these meetings regarding performance and benchmarking was then cascaded to the other GPs in the practice at the clinical meetings.

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 essential courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional diplomas in sexual and reproductive medicine, children's health and obstetrics and gynaecology. One of the GPs specialised in dermatology and two in diabetes. 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.

The practice had a system for all staff to have an annual appraisal. The appraisals identified learning needs from

Good

Are services effective?

(for example, treatment is effective)

which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example in family planning and cervical cytology.

The practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

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. They were assigned to six local care homes. Each home had a GP who visited it weekly in addition to home visits as required. The practice also worked with the community matron who saw housebound patients in the community with long term conditions such as COPD and heart failure. This allowed better monitoring of the housebound patient and reduced the need for frequent GP visits. The community matron had access to the patients' electronic record and updated them accordingly following their visits.

Blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the NHS 111 service were received by the practice 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 these communications. Out-of hours reports, NHS 111 reports and pathology results were all seen and acted on by a GP on the day they were received. There was a buddy system in operation so if the patient's GP was not on duty another would see and complete any necessary actions. Discharge summaries and letters from outpatients were usually seen and acted on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the actions required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were similar to expected at 16% compared to the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw that the policy for acting on hospital communications was working well in this respect.

The practice held multidisciplinary team meetings every three months to discuss patients with complex needs. For example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and the community matron and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the district nurses and community matron.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record which provided faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

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. 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

Good

Are services effective?

(for example, treatment is effective)

the key parts of the legislation and were able to describe how they implemented it. The practice had a consent policy to give guidance to staff when seeking consent from patients.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed every six to twelve months and had a section stating the patient's preferences for treatment and decisions. 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 the Gillick competency test and were supported by the electronic system in their decision making. These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example a written consent form was used for specific procedures such as joint injections, and the insertion of intrauterine devices. The form was then scanned and kept in the patient's electronic record.

Health promotion and prevention

The practice met with the CCG and other practices in the locality to assess the health and social care needs of the local area. This information was used to help focus health promotion activity, for example an area they had targeted was weight management.

All new patients registering with the practice were asked to complete a questionnaire to help identify any health issues. Anything identified for example long term conditions was highlighted to the GP and a note made on the patient's record. All health concerns were followed up in a timely way. The GPs and nurses used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 24 years and offering smoking cessation advice to smokers. Obese patients with pre-existing medical conditions were offered a referral to weight loss classes as well as reduced subscription rates at a local gym.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 106 patients in this age group took up the offer of the health check.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 85% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 73% of these patients.

The practice's performance for the cervical screening programme was 94%, which was above the national average of 82%. There was a policy to send letters to patients who did not attend for their cervical screening test and an alert was placed on the patient's electronic record if they had not attended so they could be reminded when attending the practice for other issues.

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 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 77%, and at risk groups 48%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 94% to 99% and five year olds from 92% to 96%. These were comparable to other practices in the locality.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014.

The evidence from this survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated comparably with other nationally for patients who rated the practice as good or very good. The practice was also average in most areas for its satisfaction scores on consultations with doctors and nurses. For example:

- 84% said the GP was good at listening to them compared to the CCG average of 88% and national average of 87%.
- 86% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 94% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 91% said the nurse was good at listening to them compared to the CCG average of 91% and national average of 91%.
- 93% said the nurse gave them enough time compared to the CCG average of 92% and national average of 92%.
- 96% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and they were all positive about the service experienced. Patients felt the practice offered a very good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three of the cards in addition to the positive comments had remarks about the appointment system and how it is sometimes difficult to get an appointment with the GP of choice. There was one negative comment about a GP however there were many positive comments about how professional and helpful all levels of staff were. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception desk was open and telephones were answered at the desk but the reception staff informed us that they had received training in confidentiality. They also said they would not repeat aloud any patient identifiable information, for example names and addresses. There was also a line on the floor in the reception area that patients were asked to stand behind until a receptionist was free. This prevented patients overhearing potentially private conversations between other patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. The patient waiting area was away from the reception desk which also assisted in keeping patient information private. There was also a separate area to the side of the reception desk that patients could be taken to if they wanted to speak in private. This area had a low desk that could be used to speak to patients in wheelchairs.

The practice manager informed us that there was normally a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. However this had been removed during recent redecoration of the practice. They were planning to put this back so receptionist staff could refer to it to help them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

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. Although the practice scored slightly below the CCG and national averages in these areas they were still generally rated well. For example:

Good

Are services caring?

- 79% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 73% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%.
- 84% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.
- 81% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 85%.

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

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 80% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff were helpful, caring and supportive.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. For example Macmillan Cancer Support and Asthma UK. The practice's computer system alerted GPs if a patient was also a carer. There was a carers' noticeboard in the patient waiting room with information showing the various avenues of support available to them. A member of the administration team had recently been nominated as a carers' champion, they made sure that identified carers were recorded correctly on the computer system to ensure their eligibility for support and additional services for example annual flu vaccinations.

Staff told us that if families had suffered a bereavement, their usual GP was informed who made an assessment whether to contact them to offer advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's 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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice manager and one of the GPs attended the local CCG meetings. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example all practices needed to identify a carers' champion and act on the guidance of prescribing medications for patients diagnosed with dementia.

The practice had carried out its own survey of 310 patients in conjunction with the patient participation group (PPG) in 2014 looking at telephone access and the appointments system. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. They had increased the availability of reception staff at peak times to answer the telephones. They had also changed the practice telephone number from a premium rate to local number to reduce the cost to patients when accessing the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and those with long term conditions. Lister House had been accredited as a Purple Star practice and promoted health equality for people with learning disabilities through staff training improving health care for people with learning disabilities. The majority of the practice population were English speaking patients and there was little demand for translation services. A translator could be accessed via the CCG if required. There was a facility on the practice website to translate its content into different languages via clicking on a translate page link. The patient waiting room had information on advocacy services available for patients to support them in their decision making.

The practice had facilities over two floors. Staff informed us that patients with mobility problems would be seen on the ground floor although there was a lift available if they did needed to go to the first floor. There was a ramp and wide doors at the front entrance and a door bell for patients who required assistance to open the doors. There were two access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Patients of no fixed abode who needed to see a GP were registered as temporary patients or directed to the local walk in service. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. The practice manager had delivered in house training on customer service to the reception staff to enable them to communicate calmly and sensitively with all patients.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. Appointments were available from 8am to 6pm and a GP was available for any emergencies until 6.30pm. Evening appointments were available until 7.30pm on Mondays and early morning appointments from 7am were available on Thursdays. The practice also opened on the last Saturday morning of the month with appointments available to see both GPs and nursing staff. These were especially useful for patients of working age or school children who could not attend during normal appointment times. One of the nurses ran a minor ailment clinic most mornings that provided same day appointments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. Home visits were made to six local care homes on specific days each week, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 71% were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 76%.
- 65% described their experience of making an appointment as good compared to the CCG average of 65% and national average of 74%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice.

Three of the comments cards we received expressed some dissatisfaction with the appointments system but others were happy with it. Routine appointments were available for booking three weeks in advance.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. One of the GP partners was also identified as a complaints lead.

We saw that information was available to help patients understand the complaints system on the practice website and in the patient information booklet. 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.

We looked at 10 complaints received in the last 12 months and found they were satisfactorily handled in a timely way. Apologies were given when necessary.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision and values that could be found in the practice leaflet and on the website. This was to provide and deliver first class primary care services for patients and whilst doing so maintain respect and confidentiality.

We spoke with a eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing 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. We looked a selection of these policies and found they were relevant and reviewed regularly. All policies and procedures we looked at had been reviewed were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a lead GP for safeguarding. 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 GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we saw audits looking at prescribing and foot assessments for patients with diabetes. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example a fire risk assessment had been completed with actions identified to maintain safety in the event of a fire.

Performance, quality and risks were discussed in the clinical and staff meetings. We looked at minutes from these meetings to confirm this.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy and the recruitment policy which were in place to support staff. We were shown the 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 a whistleblowing policy which was also available to all staff in the staff handbook.

Leadership, openness and transparency

Staff informed us there was an open culture within the practice and they felt the partners and the practice manager were approachable and always took the time to listen to all members of staff.

We saw from minutes that team meetings were held every quarter and staff were able to contribute to the agenda and raise any issues. They informed us they were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from a wide age range from 16 plus years. A survey had been carried out in 2014 regarding telephone

Are services well-led?

Good

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

access and appointment booking. The results of this survey could be found on the practice website. We spoke with a member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

The practice had also 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. One member of staff told us that they had asked for specific training around summarising clinical notes and this was being arranged. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 four staff files and saw that annual appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We looked at minutes from meetings which confirmed this.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.