Front 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 carried out an announced, comprehensive inspection at Front Street Surgery on 10 December 2014 of Front Street Surgery. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- People told us they were treated with professionalism and respect, and that the practice responded well to patients that were visiting the area for patient care and support.
- The practice worked well with other providers, especially around long term conditions and palliative care.
- The practice offered a variety of pre-booked appointments, extended opening hours and regular home visits.
- Incidents and complaints were appropriately investigated and responded to.
- The practice had a good governance system in place, was well organised and actively sought to learn from performance data, complaints, incidents and feedback.
- The practice actively sought the opinions of staff and patients, working with a well-established patient participation group (PPG).
- The practice showed a patient centred approach to delivering care and treatment.
- The practice was proactive in improving health and access to services and engaged with other health and social care agencies to improve access and patients health.

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

Importantly the provider should:

- Ensure all staff are aware of policies and make them readily available.
- Ensure Infection Prevention Control (IPC) audits are kept up to date.

Summary of findings

- Ensure annual appraisals are completed for all staff.
- Complete chaperone training for administration staff if conducting chaperone duties.

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 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 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 the National Institute for Health and Care Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their role and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. There was some evidence of appraisals and personal development plans for all staff but not all appraisals had been completed. Staff worked effectively with multidisciplinary teams and agencies.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said 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 staff maintained patient confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice learned from complaints and shared learning with staff and other stakeholders.

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Are services well-led?

Good

The practice is rated as good for providing well-led services. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by the management team. The practice had a number of policies and procedures to govern activity and held regular staff meetings.

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on as required. The practice promoted patient surveys including the friends and family test which patients were encouraged to complete on attendance at the practice. The patient participation group (PPG) was active in monitoring the performance of the practice and conducted annual patient surveys. Staff had received induction, however not all staff had received regular performance reviews.

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. There were two care homes in the practice area and a named dedicated GP provided health care support and input to the homes on a weekly basis. 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 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 regular review was undertaken 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 and or specialist nurses 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 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.

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 these groups had been identified and the practice had adjusted the

Summary of findings

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.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and families. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability or those who required it.

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). People experiencing poor mental health had received 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 also 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 received 23 completed CQC comment cards from patients, all of which were positive about their experience using the services provided. We spoke with 18 patients on the day of our inspection of which the majority were in the older population group. All patients we spoke with were complimentary about the care they received from the GPs and felt that staff treated them with dignity, were caring and compassionate.

We spoke with specific patient groups and they were able to tell us of their experiences, in particular people with long term conditions and older people. We also spoke with people from different age groups; including parents with children and people who had retired. They were all very happy with the services the practice provided. Patients also commented on the positive compassion showed by GPs who sent condolence cards to the families of bereaved patients.

Patients told us they said they felt they were always given enough time during their appointment and spoke highly of the GPs. Due to the size of the practice and population, the majority of patients were well known by all the staff and therefore could offer a more personal support experience. We observed this in most cases during our observations. The practice had trained nursing staff in sign language to assist patients with hearing difficulties although we did not see this in use during our visit.

We saw that the practice were continually seeking feedback from patients to shape and develop services in the future. We saw that patient views were listened to and the results of patient surveys were reviewed annually by the Patient Participation Group (PPG). 53 patient questionnaires were submitted in 2014 and the results showed that 85% of patients were interested in booking appointments on-line and 88% were interested in ordering repeat medication on-line. We saw that the practice had implemented this service to its patients.

In addition to the PPG survey the review of the national GP survey results for 2014 identified that 266 surveys had been sent to patients between January and September 2014. 95% commented their GP was good at listening to them whilst 91% commented their GP was good at involving them in decisions about their care. 98% of patients commented that the last time they saw the nurse they were good at treating them with care and concern. We looked at information available in the national patient survey information and it was noted that this was higher than the CCG average.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff are aware of policies and make them readily available.
- Ensure Infection Prevention Control (IPC) audits are kept up to date.
- Ensure annual appraisals are completed for all staff.
- Complete chaperone training for administration staff if conducting chaperone duties.

Front Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included an expert by experience, a GP and a practice manager.

Experts by Experience are part of the inspection team and are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Front Street Surgery

The practice delivers primary care under a General Medical Services (GMS) Contract between themselves and NHS England for patients living in Acomb and surrounding areas. The practice has four GP partners, two male and two female. The practice is a teaching practice for Hull, York medical School for first and second year students and they gain a new GP registrar every six months.

The practice opening times are from 8am to 6pm. In addition there are extended hours appointments available on Monday and Thursday evenings from 6pm to 8.45pm by specific appointment. Saturday appointments are available one in every three weeks from 8.15am to 10am. The practice does not provide an out-of-hours service to their own patients but they are automatically diverted to the local out-of-hours service Prime Care, when the surgery is closed in the evenings and at the weekends.

Why we carried out this inspection

We inspected this service as part of our inspection programme. This provider had not been inspected before 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.

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may had poor access to primary care
- People experiencing a mental health problems

Detailed findings

Before visiting Front Street Surgery, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We asked York CCG NHS York and the Local Healthwatch to tell us what they knew about the practice and the service provided. We asked the surgery to provide a range of policies and procedures and other relevant information before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection visit on 10th December 2014. During our inspection we spoke with a range of staff including GPs, a practice nurse, health care advisor and administration and reception staff. We spoke with 18 patients who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed 23 CQC comment cards where patients and members of the public shared their views and experiences about the service.

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to monitor patient safety and had a good track record for maintaining patient safety. We looked at the significant events analysis over the last year and saw that there were nine separate events identified. Learning and actions were recorded with the dates of when reviews took place.

Our discussion with GPs, nurses and non-clinical staff showed that they fully understood the relevant protocols for providing good safe care but the process for learning from incidents was not fully implemented. Staff told us that significant events analysis (SEA) discussions took place at weekly meetings and that this was a scheduled item on the meeting agenda.

Staff were clear on what action to take in the event of an incident occurring. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, indicated that in 2013/14 the practice was appropriately identifying and reporting incidents.

Staff were aware of the process for identifying safety and medication alerts. Safety alerts were circulated electronically within the practice. Staff knew who was responsible for issuing alerts and the process for implementing changes as a result of alerts being issued.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events and our conversations with them confirmed their awareness of this. We saw that any significant event had been recorded and there were documented details of the event, how learning was implemented and actions taken to reduce the risk of them happening again.

National patient safety alerts were communicated via computer alerts to practice staff. We saw that alerts were also discussed at weekly practice meetings, to ensure that staff were aware of any relevant to the practice and where action needed to be taken in a timely manner. We saw examples where specific drugs had been discontinued and information about the Ebola virus and staff had been notified internally to ensure the latest information was available.

The practice had in place a process for complaints and there was clear information available for patients should they need to make a complaint about the practice or staff. We saw one complaint had been recorded during the last 12 months and action and learning from the complaint was recorded.

Reliable safety systems and processes including safeguarding

There were policies and procedures in place to support staff to report safeguarding concerns to the named responsible GP within the practice and to the local safeguarding team. Staff we spoke with demonstrated an understanding of safeguarding patients from abuse and the actions to take should they suspect anyone was at risk of harm. Although staff were clear on how to access safeguarding policies, they were not aware of how to access all policies for the practice We discussed this with the manager and they assured us that they would re-enforce how staff access policies on their internal systems immediately.

Nursing staff also told us that they were involved in clinical meetings when changes to services occurred or any QOF amendments had been released.

We saw evidence that all staff had received different levels of safeguarding training for adults and children. The practice had identified a nominated professional as a safeguarding lead who had completed level three training to allow them to carry out this role. We saw records of weekly clinical meetings that included discussions around new and existing patient concerns.

There was a system to highlight vulnerable patients on the practice's electronic record. This included information to make staff aware of any relevant issues when patients attended appointments. The practice conducted regular discussions on vulnerable patients at their weekly meetings and further review took place three monthly with the primary health care team.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness

for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. However, reception staff had not undertaken training in order to fully understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We spoke with the practice manager and they assured us that reception staff will no longer perform these duties or if they did they would undertake appropriate training beforehand.

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 clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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.

The practice had up to date medicines management policies and prescribing protocols in place. We saw that medicines for use in the practice were stored securely and only clinical staff had access to them. GP bags were regularly checked to ensure that the contents were intact and in date. There were processes in place to ensure that stocks of medicines such as vaccines were readily available, in date and ready to use. We looked at how vaccines were ordered and saw that they were checked on receipt and stored appropriately in accordance with the manufacturers recommendations.

Some medicines were stored in a lockable fridge and staff recorded the temperature daily to ensure medicines were stored in line with manufacturer's recommendations.

Staff were able to demonstrate the process and audit trail for the safe management of prescriptions and the authorisation and review of repeat prescriptions. Prescription pads and repeat prescriptions were stored securely.

Cleanliness and infection control

We observed all areas of the practice to be clean and tidy. The practice had an infection prevention and control policy (IPC). The practice also had a nominated infection control lead. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The IPC lead completed internal audits and we saw that the last audit was completed in 2012. We spoke with the IPC lead and the practice manager and they assured us that IPC audits would be completed on a more regular basis.

Patient toilets were observed to be clean and had supplies of hot water, soap, paper towels and hand sanitizer. Aprons, gloves and other personal protective equipment (PPE) for staff were available in all treatment areas. Sharps bins were appropriately located, labelled, closed and stored after use. Disposable curtains were used in consulting and treatment rooms, which were labelled with disposal dates. There were arrangements in place for the collection of general and clinical waste.

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 germ found in the environment which can contaminate water systems in buildings). We looked at records that corroborated this.

Equipment

There were processes in place to regularly check and calibrate equipment used in clinical areas. We saw records showing that equipment had been serviced and maintained at required intervals and to the manufactures recommendations. These measures provided assurance that the risks from the use of equipment were being managed and people were protected from unsafe or unsuitable equipment.

Staff we spoke with told us there was enough equipment in place to meet their needs. If equipment was deemed to be faulty it was either repaired or replaced immediately. We saw that equipment checks were carried out on a monthly basis and staff where aware of whom to report maintenance issues or faults to.

Good

Are services safe?

We also saw that annual checks on portable appliance electrical (PAT testing) equipment had taken place previously and was currently being arranged for the 2014/15 period. Servicing arrangements were in place; for example for oxygen and pulse oximeter equipment.

Staffing and recruitment

The practice had a recruitment policy and process in place. We looked at three staff files and appropriate checks had been carried out before the staff member began working within the practice. Staff had a recent Disclosure and Barring Service checks (DBS) in line with the recruitment policy. We saw that there was an appropriate level of skill mix of staff in the practice.

Staff told us that the levels of staff and skill mix was currently appropriate to meet the needs of the practice. Staff also told us that there was a seasonal increase of school age children wanting appointments particularly in the school holiday periods. The practice made appropriate adjustments to allow for this increase by managing the scheduled appointments and working times of available GPs.

Staff we spoke with were flexible in the tasks they carried out. This meant they were able to respond to areas in the practice that were particularly busy or responding to busy periods. For example, reception and administration support was increased at busy times and other staff completed administration tasks.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included monthly checks of the building, the environment, treatment rooms, waiting areas, dealing with emergencies and equipment. The practice also had a health and safety policy and health and safety information was available to staff on the practice electronic system.

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses were allocated lead roles or areas of responsibility, for example safeguarding and infection control. Procedures were in place to assess, manage and monitor risks to patients and staff safety included fire risk assessments and monthly health and safety/environment checks.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, patient areas and risk assessments for the health and safety and environment of the practice. These were all kept up to date to ensure patients and staff remained safe at all times.

Staff were able to identify and respond to the changing risks to patients including any deterioration in their health and well-being or for medical emergencies. The practice monitored patients where they had a range of conditions for example; healthy heart reviews, thyroid reviews and chronic obstructive pulmonary disease (COPD) reviews.

Those patients with long term conditions were reviewed on a monthly basis and a recall system was in place. If required, palliative care professionals were engaged in detailed discussions regarding on-going care assessments.

The staff gave examples of how they utilised standard clinical templates on the patient administration system to ensure appropriate care and treatment was given and easily recorded. An example of this was for patients experiencing mental health conditions and the efficient use of their recall system in order to maintain a balanced approach to managing their healthcare.

The practice monitored the health of patients who were over the age of 75 and all had a named GP. All enquiries from this patient group were directed to their named GP to ensure continuity of care and support.

Patients with long term conditions who had changes identified in their condition or new diagnoses were discussed at weekly clinical meetings. That allowed clinicians to monitor treatment and adjust it according to risk. For example patients who required palliative care were discussed in multi-disciplinary team meetings and the practice was following the 'gold standards' framework for palliative care.

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 to attempt to restart a person's heart in an emergency). When we asked members of staff,

Good

Are services safe?

they all knew the location of this equipment and records confirmed that it was checked regularly. All of the staff we spoke with knew how to react in urgent or emergency situations.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Staff we spoke with were aware of the practice business continuity arrangements and how to access the information they needed in the event of emergency situations.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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. 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 and updated when appropriate.

Staff told us they received guidance issued by the National Institute for Health and Care Excellence (NICE) electronically. They told us that the practice manager was responsible for circulating them to clinical staff. We saw examples where treatment guidance had been circulated to staff and acted on.

We spoke with a range of patients during our visit and they all were able to tell us how their treatment of particular conditions was monitored. Patients told us there were recalled regularly for monitoring of their condition for example; patients with long term conditions, diabetes, younger people and working age groups.

The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice. The practice reviewed all aspect of the service both clinical and non-clinical. Examples of these were patient survey results, calls received, calls answered appointments attended and referrals sent. The practice used the Quality Outcome Framework (QOF) for monitoring its clinical services, examples were; unplanned admissions, prescribing and children's vaccinations. The practice used electronic systems s to identify patients with complex needs and they had multidisciplinary care plans documented in their case notes. We saw there were processes in place to review patients recently discharged from hospital, who needed to be reviewed by their GP.

Staff had a good understanding of the Mental Capacity Act 2005 and ensured the requirements were complied with. Staff were able to identify patients who needed to be supported to make decisions and identify where a decision needed to be made in a person's 'best interest'. The practice offered an advocacy service where patients were identified as needing support during their appointments or with their care decisions. Information about advocacy services was available to all patients.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients to secondary care (the NHS trust) and patients with suspected cancers who needed to be referred and seen within two weeks. We saw evidence that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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 taken into account in this decision-making as appropriate.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Staff across the practice had key roles in monitoring and improving outcomes for patients. Systems were in place that monitored outcomes for people for example patients with chronic conditions had colour coded markers for overdue or not due reviews and Looked After Children (LAC) records had automatic indicators added to ensure all LAC were managed appropriately.

The practice had a system in place for completing clinical audit cycles. The practice showed us three clinical audits that had been undertaken in the last two years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved The three audits we looked at were prescribing, dementia diagnosis rates and patients taking medication that were having regular thyroid function tests (TFTs).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients who were current smokers whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months was 99.9%. Patients who were diagnosed as having

dementia or a mental health condition who's notes contained support in the preceding 12 months was 100%, which was above the CCG average and NHS England average.

The practice met all the minimum standards for QOF in cancer/asthma/chronic obstructive pulmonary disease (COPD) and depression. This practice was not an outlier for any QOF (or other national) clinical targets.

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. GPs told us the practice had implemented system recalls for patients with chronic conditions for example diabetes, healthy heart, thyroid stroke, renal and hypertension. There was a system in place for identifying specific patient conditions and when recalls were about to take place and further follow up contact as required.

There was a protocol for repeat prescribing which was in line with national guidance. The practice was an early adopter of electronic prescribing. This was in response to patient feedback and allowed patients faster access to prescribed medication via their nominated pharmacy. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had weekly internal as well as multidisciplinary meetings every three months to discuss the care and support needs of patients and their families. The practice participated in benchmarking its performance by reviewing the QOF and National Patient Survey data. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

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 attendance at mandatory courses such as fire and basic life support. All GPs were up to date with their yearly continuing professional development requirements and 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).

Some staff had undertaken annual appraisals that identified learning needs from which goals and objectives were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example chronic disease management. However, not all staff had received their annual appraisal and the practice manager told us that the remaining staff would have their appraisals completed in the next three months. As the practice was a training practice, doctors who were training to be qualified as GPs were offering extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and review of patients with long term conditions. Nurses with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease 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 people's needs and manage complex cases. It received 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 a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

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 social

workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. Electronic systems were also in place for making referrals, through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments). Staff reported that this system was easy to use.

The practice has also signed up to the electronic Summary Care Record. This system enabled staff in the practice to see and treat patients from other practices registered within the group. These records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems in place to provide staff with the patient 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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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 to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had processes in place to help staff, for example with making do not attempt resuscitation orders. This highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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 annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the past, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice asked new patients to complete a new patient registration form. This could be done online or in the practice. There were also facilities online for non-English speaking and temporary residents to register with the practice. The registration form was detailed and asked the patients how they would prefer to communicate with the practice. This provided the practice an opportunity to promote different methods of communication such as electronic communication. The GPs were informed of all health concerns detected and these were followed up in a timely way.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical screening uptake was 95.6%, which was slightly below the national average. There was a policy to offer reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend and failed to respond to further appointment invitations. Performance for national

Good

Are services effective?

(for example, treatment is effective)

contraception, maternity services and child health in the area were in line with average for the CCG and a similar mechanism of following up patients who did not attend was also used for these programmes.

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 all immunisations was below average for the CCG, and there was a clear policy for following up non-attenders in the practice.

The practice kept a register of patients who were identified as being at high risk of admission, or at the end of their life and had up to date care plans in place for sharing with other providers. We saw that patients in this group were followed up after admissions and the practice used resources available to prevent readmission. Examples of these were the development of care plans where needed and working with the community support team.

The clinical staff we spoke with told us they provided health promotion and lifestyle advice. Staff also told us they often tried to get the patient to self-manage their health and offered health promotion booklets and other information as appropriate. The patients we spoke with confirmed this. We found evidence of good access and sign posting for young people towards sexual health clinics or offering extra services and contraception.

We saw the practice were aware of people whose circumstances may make them vulnerable. The practice held a register of those in various vulnerable groups such as those with learning disabilities.

People experiencing poor mental health in the practice had access to services. We saw that people with severe mental health problems received an annual physical health check. We saw staff had undertaken additional training in mental health and addiction. There was a good understanding and evidence of signposting patients to relevant support groups and third sector organisations operating in the local area.

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 and annual Patient Participation Group (PPG) survey carried out on behalf of patients. The evidence from these sources showed patients were generally 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 proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as in the middle range was 85% which was slightly above the national average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards. All 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. We also spoke with 18 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 observed patients were dealt with in a kind and compassionate manner. We saw staff being polite, welcoming, professional and sensitive to the different needs of patients. We also observed staff dealing with patients on the telephone and saw them respond in an equally calm professional manner. Staff we spoke with were aware of the importance of providing patients with privacy. They told us they could access a separate treatment room off the reception area if patients wished to discuss something with them in private or if they were anxious about anything.

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 team leader told us she would investigate these and any learning identified would be shared with staff and the business management team.

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 and generally rated the practice well in these areas. For example, data from the national patient survey showed 91% said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were in line with national averages.

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

Staff told us that translation services were available for patients who did not have English as a first language. However, we did not see any information in the reception area informing patients this service was available, but staff were aware of what to do in the event of this service being requested.

Patient/carer support to cope emotionally with 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 and generally rated the practice well in these areas. 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 responded compassionately when they needed help and provided support when required.

Good

Are services caring?

GP's referred people to counselling services where necessary, and the practice website and handbook contained links to support organisations and other healthcare services. Patients could also search under their local area for further advice and support.

The practice provided information and support to patients who were bereaved and for carers. The practice sign posted patients to health and social care workers and referrals were made on behalf of patient's relatives and carers as appropriate. GPs told us they always put relatives on a visiting list after bereavement.

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 people'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 practice supported a large population of older patients and regular home visits were scheduled for a named GP. Protected time was allocated to GPs for home visits for patients to ensure continuity of care.

The practice provided services that were accessible to working age people There were a mixture of appointment times, telephone consultation, text reminders, and emergency clinics. We saw that patients could also access services at the branch practice if this was closer to their work place.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. We saw that they had developed actions for the each year and some that were continued from the previous year. Examples of these were improving communication via the reception notice boards, providing easier access to appointments by introducing appointments online, and the ability to book repeat prescriptions online.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

They recognised those with a learning disability, younger people, ethnic groups and the older population.

Staff were knowledgeable about how to book interpreter services for patients where English was their second language. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The practice had recognised the needs of different groups in the planning of its services. Staff could access other support services for example Alcohol Advice Service or Age Concern for up to date information in order to support patients as needed.

Patients with disabilities and patients with pushchairs were able to access all areas of the building. The practice also had accessible toilet facilities that were available for all patients attending the practice including baby changing facilities. We observed people who were using a wheelchair and needing access to the building, obtaining assistance from staff to attend their appointment.

An audio loop was not available for patients who were hard of hearing. However, nursing staff were trained in the use of sign language and patients were also encouraged to bring another person or family member with them to their appointment.

Access to the service

Appointments were available from 8am to 6pm Monday to Friday and extended appointments available on Monday and Thursday evenings from 6pm to 8.45pm by specific arrangement. Saturday appointments run one in three out of each month from 8.15am to 10am. The practice did not provide an out-of-hours service to their own patients directly and patients were automatically diverted to the local out-of-hours service Prime Care, when the surgery was closed in the evenings and at the weekends. The practice also offered clinics at the surgery for example; Family planning, diabetes Asthma and chronic obstructive pulmonary disease clinics.

Comprehensive information was available to patients about appointments on the practice website and in a practice leaflet. This included how to arrange urgent appointments, 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. 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. This also included appointments with a named GP or nurse. Visits were made to the local care homes. There was one nominated GP who undertook this role in the practice.

All 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were able to use the online booking system and found it easy to use. The practice also offered text message reminders for appointments and test results. The premises were accessible for people with limited mobility such as wheelchair users and all patient areas were clean and well-maintained.

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. There was an email address and postal address provided for patients to make a complaint directly.

We saw that information was available to help patients understand the complaints system in the waiting area, in the practice leaflet or the website. 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 one complaint received in the last 12 months and found this had been satisfactorily handled and dealt with in a timely way. We saw that the practice had an openness and transparency when dealing with the complaint.

We spoke with members of the PPG and they felt that the practice always took complaints seriously, handled them in a timely manner and resolved them fully. The PPG also felt that the practice took suggestions from the PPG seriously and acted on them with patient satisfaction in mind.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's future plans.

The practice values, vision and goals were available in the practice leaflet and on the practice website. Staff told us that they had weekly meetings with their manager where their role in meeting these goals was discussed. Examples of the practice vision and values included being committed to family medicine both in a traditional way and responding to changing needs.

We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw evidence of good communication with staff. Staff also stated they could approach any colleague in the practice at any time to discuss any concern or issue rather than wait until a meeting occurred as the culture was open and supportive.

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 at these policies and procedures and spoke with staff and we saw that some staff required further policy awareness. We spoke with the practice manager and they told us they were in the process of re-issuing all policies to staff and had a plan to re-implement all policies across the practice. All of the policies and procedures we looked at had been reviewed and 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 the senior partner was the lead for safeguarding. The senior partner was also named as the Caldicott Guardian. The Caldicott Guardian is responsible overall for the safe use of confidential information, consent and data access requests. We spoke with seven 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 QOF 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 team meetings and action plans were produced to maintain or improve outcomes.

The practice had detailed arrangements for identifying, recording and managing risks. We saw that the risks identified were discussed at team meetings and updated in a timely way.

The practice held regular practice meetings. We looked at the minutes from the meetings over the last year and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes of staff meetings that they were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings and with their line manager. We also noted that there was regular staff consultation.

The Practice Manager had responsibility for HR management across the practice. We reviewed a number of policies, for example disciplinary procedures, the induction policy, and sickness which were in place to support staff. We saw that these were well laid out and easy to understand. However, not all staff were aware of or clear on how to access policies.

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

The practice had gathered feedback from patients through patient surveys, friends and family test and complaints received. The practice had an active Patient Participation Group (PPG) which was made up of representatives from the main and branch practice. The PPG included representatives from various population groups; including older people and working age adults. The PPG had supported surveys and met every quarter. We saw that following the annual surveys priority areas were agreed with the PPG and these formed the basis of the initial practice objectives. Examples of these were improved channels of communication with patients, updating of the practice website and the implementation of online services for appointments and prescriptions.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they

Are services well-led?

Good

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

would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff 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.

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 staff files and saw that some regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and we saw evidence to confirm this.

The practice was a GP training practice and they received a new GP registrar every six months at Front Street Surgery. We saw that there were suitably qualified GP trainers available in the practice to support the registrars.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice learned from and improved outcomes for patients. For example improved security arrangements around faxing information externally out of the practice.