Carlton 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 inspected this service on 13 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, caring, effective, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, working age people, people in vulnerable groups and people experiencing poor mental health.

Our key findings were:

- Performance was consistent over time and patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred.
- Patients received evidence based assessments and care and treatment was planned and delivered to promote a good quality of life
- Staff treated patients with respect and kindness. Patients told us that staff were caring and compassionate. They said that they had confidence and trust in the GPs they saw or spoke with.
- Services were planned and delivered to meet the needs of the patients. The practice was aware that improvements were needed to the appointments system to enable improved access for patients. Some changes have been made to the call back system for patients and this was being closely monitored
- The leadership and management within the practice promoted an open and transparent culture. Staff felt supported and able to contribute to the running of the service. The practice sought and acted on feedback from staff and patients

An example of outstanding practice that we saw was:

- The practice had implemented a new initiative in conjunction with the Clinical Commissioning Group

Summary of findings

(CCG) which involved employing and developing newly qualified nurses and nurses new to practice nursing. This was a proactive approach to begin to address the future skill gaps in the workforce in general practice.

We identified one area for improvement. The provider should:

- Develop staff knowledge of the Mental Capacity Act 2005 in relation to their roles

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 effective. Our findings showed systems were in place to ensure that all clinicians were up-to-date with NICE guidelines. We also saw evidence that these guidelines were used to influence and improve practice and outcomes for patients. The practice had low referral rates to secondary services due to in-house provision of services for patients. Staff received training appropriate to their roles and further training had been identified and planned. There were detailed and thorough training logs completed for staff which included robust competency assessments.

The practice supported patients who had mobility problems to attend the practice. A transport service was funded and provided by the practice to support patients with poor mobility to attend the practice to see the district nurse, practice nurse and GP. If necessary the patient could see all of the clinicians they needed to during one visit.

Are services caring?

Good

The practice is rated as good for caring. Patients told us they were treated with dignity and respect at all times and that they considered the practice to be very caring. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. The practice referred to the Gold Standard in caring for patients nearing the end of their life. This ensured their care was reviewed appropriately and that patients were supported to make decisions about their care and treatment for as long as possible.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure

Summary of findings

service improvements where these were identified. Patients gave a mixed response to access to the practice for appointments and the practice was implementing a new appointments system to address the issues. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strong values to deliver a high quality of care for patients. Staff felt supported and valued and were clear about the vision. There was visible leadership which encouraged team work and promoted an open and transparent culture. The practice had a number of policies and procedures to govern activity, and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and had acted on this. The practice had an active patient participation group (PPG) who felt listened to and were able to contribute to the running of the service. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. The practice had a systematic approach to managing the health of older patients. The practice worked in partnership with the district nursing and health visitor teams to support housebound older patients. Patients over the age of 75 years of age had a named GP to provide continuity of care and reduce risk. The practice provided an opportunity for older patients to access a range of health care including home visits from both GPs and a practice nurse when appropriate. The practice supported patients who had mobility problems to attend the practice. A transport service was funded and provided by the practice to support patients with poor mobility to attend the practice to see the district nurse, practice nurse and GP.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. There were systems in place for identifying and managing patients with long term conditions and the practice offered a flexible appointment system to meet their health needs. For example patients with long term conditions such as asthma or diabetes were able to book times to suit them and did not have to fit around fixed clinic times. The practice had introduced a care plan for all new diabetic patients which provided a personal plan of their health needs and how these were being met. The practice also provided a weekly clinic to review and monitor patients who were using anticoagulation therapy which patients said they felt was extremely convenient.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children who were at risk. For example, children and young people who failed to attend appointments. Immunisation rates were relatively high for all standard childhood immunisations in comparison to other practices in the Clinical Commissioning Group (CCG). We saw that the practice had worked with parents and schools to reduce the number of children who attended the accident and emergency department at the hospital.

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. There were no fixed time clinics held at the practice and therefore appointments could be made around school hours. We

saw that the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women who had a sudden deterioration in health. The practice provided contraceptive treatments and family planning advice.

Working age people (including those recently retired and students)

Good

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

The practice had extended opening hours once a week which was useful to patients with work commitments.

The practice offered a full range of health promotion and screening which reflected the needs of this age group including cervical smears and chlamydia testing.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had a register of patients with learning disabilities who received an annual health check. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

Summary of findings

The practice worked closely with the community mental health team who provided a service at the practice each week. The practice also sign-posted patients experiencing poor mental health to various support groups and third sector organisations when required. The practice had a system in place to follow up patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients on the day of the inspection. All of them were complimentary about the services provided at the practice. They said that the GPs and staff were very good. They told us that all the staff were kind and respectful. All of the patients told us that there was no problem at all getting an urgent appointment to see or speak with a GP.

We spoke with the vice chair of the Patient Participation Group (PPG). PPGs are away for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. They told us that they felt well supported by the practice manager and the clinicians who attended the meetings. We reviewed the 27 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. There were 21 comment cards which contained highly positive feedback about the service provided by the practice. Patients told us that all staff were respectful and treated them with dignity, including reception staff. There were five comments about the difficulty in getting through to the practice by telephone in a morning, three comments made about getting an appointment and one comment which stated that repeat prescriptions were not being reviewed.

We looked at the national GP Patient Survey information published in December 2013 which found that 79% of patients rated the practice as good or very good. This was below the Clinical Commissioning Group's (CCG) regional average and based on 106 responses. The vice chair of the PPG told us that they were aware that some patients had difficulty getting through to make an appointment in the morning. They told us that the practice was trying to improve this situation and had introduced a number of initiatives including a new appointments system and a telephone call back system. They informed us that the PPG had already carried out a patient survey about the telephone call back system. As a result of the feedback from patients, the practice had changed the system. The PPG planned to carry out a follow up survey to assess how effective these changes had been to improve access for patients.

Areas for improvement

Action the service SHOULD take to improve
The provider should:

Develop the knowledge of clinical staff in relation to the Mental Capacity Act 2005

Outstanding practice

An area of outstanding practice we saw was:

- The practice had implemented a new initiative in conjunction with the Clinical Commissioning Group (CCG) which involved employing and developing newly qualified nurses and nurses new to practice nursing. This was a proactive approach to begin to address the future skill gaps in the workforce of general practice.

Carlton Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a second CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Carlton Street Surgery

Carlton Street Surgery is a general practice located in Burton-on-Trent in the East Midlands.

The practice has five permanent GPs (three male and two female), a practice manager, a clinical manager, three practice nurses and a head of reception. There is also a reception team and administrative staff. There are almost 9000 patients registered with the practice (as at 31 March 2014). The practice is open from 8.00am to 6.00pm Monday to Friday and provides one late night service from 6.30pm to 8.30pm.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of services for example reviews for asthma, diabetes and respiratory conditions. It also offers child immunisations, contraception advice and travel health vaccines. The practice offers a minor surgery service and is the only surgery in Burton-on-Trent to offer vasectomy and carpal tunnel operations. The practice has its own purpose designed operating suite.

Carlton Street Surgery does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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?

Detailed findings

- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 October 2014. During our inspection we spoke with two GPs, a specialist nurse practitioner, the practice manager, the head of reception and a receptionist. We also contacted the vice chair of the patient participation group. We spoke with seven patients about their experiences of the care they received. We talked with carers and/or family members and reviewed relevant documents. We reviewed 27 patient comment cards sharing their views and experiences of the practice.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example a concern was raised by staff about the process of receiving interim test results for patients and the timeliness of informing them about their test results. We saw that action had taken place to try to improve this situation.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently and so could evidence a safe track record over a previous twelve month period.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. A slot for significant events was on the weekly practice meeting agenda and time was dedicated to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet or could be obtained from the reception manager. Once completed these were dealt with immediately and monitored. We saw evidence where each incident was discussed at the practice meetings and that records were completed in a comprehensive and timely manner. Evidence of action taken as a result of reporting incidents was shown to us. For example we saw that there had been an incident where a patient could not continue their telephone conversation with staff at the practice due to certain circumstances. We saw that the practice had made sure that this situation would not happen again and the patient would be supported to have a discussion with the GP whenever necessary.

National patient safety alerts were received by all designated clinical staff at the practice. Staff we spoke with were able to give examples of alerts relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all were aware of those relevant to the practice and where action was needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details of other relevant agencies were easily accessible. Records we looked showed that appropriate recruitment criminal record checks had been undertaken for all staff prior to employment.

The practice had a GP who was appointed as the lead in safeguarding vulnerable adults and children. We saw that all GPs and the practice nurses had undertaken training in safeguarding vulnerable adults and been trained to level 3 in safeguarding children. All staff we spoke with were aware of who to speak to in the practice if they had a safeguarding concern. We saw a flowchart was available in reception for staff which explained the steps they should take if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example if a patient was also a carer or had a learning disability. The system enabled the identification and follow up of children, young people and families who were living in disadvantaged circumstances. This included children at risk, children and young people with a high number of accident and emergency attendances and the review of repeat medications for patients with co-morbidities/multiple medications

We found that GPs used the required codes on their electronic case management system to ensure risks to

children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

A chaperone policy was in place and on display in the waiting area of the practice. We saw that chaperone training had been undertaken by the reception manager and three receptionists. Staff we spoke with understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination appropriately.

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

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 medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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.

We saw records that detailed the actions taken in response to reviews of prescribing data. For example, the patterns of antibiotic prescribing. We saw that the practice was 'better than average' compared with other practices locally for the number and type of non-steroidal anti-inflammatory prescribing within the practice. We saw that the practice had a lead GP for medicines management who worked closely with the practice pharmacist and medicines management team at the Clinical Commissioning Group. This GP was responsible for ensuring any changes to prescribing guidance received by the medicines management team was shared with the other clinicians. We saw an example of this in respect of a type of medicine used for nausea.

The lead GP told us that they had worked with the medicines management team to visit other practices in the locality to discuss their prescribing practices. This helped them to determine what worked well and what could be shared amongst the group of practices. The GP informed us that they intended to set up medicines management clinics which would be operated by the practice pharmacist to ensure an effective and robust approach to medicines management was maintained at all times.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of these directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, it described how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. The reception manager and one other member of staff were 'prescribing champions' and attended a training course twice per annum arranged with the medicines management team at the Clinical Commissioning Group (CCG). The practice manager told us that they worked closely with the medicines management team and had worked with them on a recent medicines waste management campaign.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We were give examples of how the procedure was being followed in relation to the management of specific high risk medicines such as those used for conditions such rheumatoid arthritis.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had a prescriptions security policy and a blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Good

Are services safe?

Cleanliness & Infection Control

We observed the premises to be 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 clinical manager was the lead for infection control at the practice and all staff received induction training about infection control specific to their role and there after annual updates. We saw evidence of an infection control audit completed in 2013 and minor improvements identified for action were completed on time. We also saw evidence of other audits carried out by the lead for infection control such as a minor surgery audit which was carried out annually.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

Hand hygiene techniques signs 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 saw records that confirmed the practice 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 sufficient 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. A schedule of testing was in place.

Staffing & Recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff 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 they was enough staff on duty. Staff told us that there was a flexible arrangement in place where they were offered additional hours to cover each other's annual leave or sickness.

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 ensure patients were kept safe.

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, 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 one of the GPs was the identified health and safety representative.

Identified risks were included in a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. Staff confirmed that risks were discussed at weekly practice meetings and within team meetings. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated

Good

Are services safe?

external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date.

A business continuity plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Each risk was identified and 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 in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

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 treatment approaches. They were familiar with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw evidence of new guidelines being shared amongst the team. We saw records which highlighted how the guidance may impact on the practice's performance and any implications for patient care were discussed. Records showed that required actions were agreed and followed through. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The GPs attended educational meetings arranged by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

The GPs told us they led in specialist areas such as diabetes, mental health and urgent care and the practice nurses supported this work which allowed the practice to focus on specific conditions. We saw that two GPs and three practice nurses were trained specifically in the treatment of diabetes and a pre-diabetes register had been set up to ensure those patients at risk received annual checks and relevant health promotion support. Four practice nurses had recently completed update training on assessments and care of patients with a learning disability in order to improve the service offered for those patients when invited for their annual health checks.

National data showed the practice was in line with referral rates to secondary and other community care services. Staff told us that they had a record of contributing to and adopting referral pathways to improve the care of the patients and to refer appropriately. An example of this was where the practice had a low referral rate to trauma and orthopaedics due to enabling patients to have joint injections at the surgery. All GPs we spoke with used national standards for referring patients with suspected cancers in order for them to be seen within two weeks.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then used to support the practice to carry out clinical audits.

The practice showed us nine clinical audits that had been undertaken in the last 12 months. We saw the practice was able to demonstrate the changes resulting since the initial audit for example those patients who were at risk of diabetes were identified for an annual recall to ensure they received the correct follow up and review. Other examples of clinical audits included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

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). The QOF rewards practices for providing quality care and helps fund further improvements. For example we saw an audit regarding the prescribing of analgesics (medicines for pain relief) and nonsteroidal anti-inflammatory drugs. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 83% of patients with diabetes who used the practice had received an annual review, and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). 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 upon the outcomes being achieved and areas where this could be improved.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts and recommendations when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also 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 comparable to other services in the area such as the percentage of patients aged 65 and older who had received a seasonal flu vaccination.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We saw evidence of a robust induction training programme which included induction packs for all new starters specific for their job role.

A good skill mix was noted amongst the doctors, for example one GP had a diploma in children's health, another GP was a member of the Royal College of Obstetricians and Gynaecologists and a third GP was an approved GP appraiser. Three practice nurses and two GPs were also trained in diabetes. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date set for their revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified training and development needs and performance objectives and agreed dates for completion. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example safeguarding and basic life support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical smears. Those with extended roles for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. 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 which were not followed up appropriately.

The practice was commissioned for a new enhanced service to follow up patients discharged from hospital and had a process in place for this.(Enhanced services are

Good

Are services effective?

(for example, treatment is effective)

services which require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the way the practice acted on hospital communications was working well in this respect.

We were provided with good examples of joint working, for example with midwives and health visitors to promote positive outcomes for mothers and children. The practice also held multidisciplinary team meetings every two months to discuss the needs of complex patients, for example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses. Decisions made at these meetings about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system in discussion with the patient. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had also signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out of hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We saw that there were mechanisms to seek and record consent decisions. We saw that there were consent forms completed by parents for children who had received immunisations and for patients agreeing to minor surgery procedures. We were shown information that was available to parents which informed them of potential side effects of the immunisations. We saw that the need for the surgery and the risks involved had been clearly documented and explained to patients.

The GPs and clinical manager (senior nurse) that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment and are capable of understanding the implications of the proposed treatment and any risks.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. One GP at the practice explained how they worked closely with the local Independent Mental Capacity Advocate (IMCA) service. The role of this service is to work with and support patients who lack capacity and represent their views and support to make decisions including those about serious medical treatment. We did not see any evidence of training for clinical staff in the Mental Capacity Act 2005.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the clinicians to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by referring patients to into a weight management programme which included dietary support and exercise classes.

The practice had numerous ways to identify patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. Similar mechanisms were in place to identify at risk groups such as

Good

Are services effective?

(for example, treatment is effective)

patients who were obese, those patients likely to be admitted to hospital and those patients receiving end of life care. These patient groups were offered further support in line with their needs.

There was a policy to offer telephone reminders for patients who did not attend for follow up appointments such as smoking cessation and appointments for cervical screening for example. We saw that the practice audited patients who did not attend for annual checks and had a number of mechanisms to chase patients who had missed their appointments.

The practice supported patients who had mobility problems to attend the practice. A transport service was funded by the practice to support patients with poor mobility to attend the practice to see the district nurse, practice nurse and GP. If necessary the patient could see all of the clinicians they needed to during one visit.

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 most immunisations was above average for the CCG, and there was a clear policy for a named practice nurse to follow up patients who did not attend.

Up to date care plans were in place that were shared with other providers such as the out of hours' provider and with multidisciplinary case management teams. Patients aged 75 or over and patients with long term conditions were provided with a named GP.

For emergency patients, the practice had signed up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Information for patients about this was available on the practice website together with a form to enable patients to opt-out from having a Summary Care Record if they chose.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013 and the survey of 277 patients undertaken by the Patient Participation Group (PPG) on the telephone call back system used at the practice. The evidence from these sources 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 2013 showed that 93% of practice respondents had confidence and trust in the last GP they spoke with or saw at the practice. Satisfaction scores on consultations with doctors and nurses showed that 80% of practice respondents felt the GP was good at listening to them and 76% felt the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 27 completed cards and the majority were highly positive about the level of care, dignity and treatment they had experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. There were five comment cards where patients had expressed difficulty in contacting the practice by telephone in the morning. Data from the national patient survey 2013 showed that only 44% of patients found it easy to get through on the phone. The practice staff were aware of this issue and showed us the action plan they had in place to make improvements. We saw that the practice had upgraded the number of telephone lines available for patients and the rostering of staff at busy times to improve the situation.

We saw that staff treated patients with dignity and respect. The practice had a written policy for treating patients with dignity. We asked staff what dignity meant to them. They described this policy and gave us examples of when they had applied its principles. We asked staff how they would deal with patients who wanted to discuss confidential issues at reception. They told us they would arrange to speak with the patient in private, however we did not see any information displayed to inform patients of this. There was a notice on the waiting room door which explained to patients that they might experience a delay whilst reception staff dealt with patient enquiries one at a time.

We also spoke with seven 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. Patients told us that the staff at the practice had time to listen to them and gave them advice without feeling rushed.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw consulting and treatment rooms had locks on internal doors, examination screens, frosted glass windows and blinds to promote patients dignity. Staff told us they would only knock on an examination room door if there was an emergency. 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 staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. A notice on the entrance door to the surgery was seen to remind patients to give other patients privacy at the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. Staff told us that patients whose circumstances may make them vulnerable were able to access the practice without fear of stigma or prejudice, for example those who were homeless or those with mental health issues. We saw that staff treated all patients in a sensitive and respectful manner.

Care planning and involvement in decisions about care and treatment

All the patients we spoke with on the day of our inspection told us they had been involved in decisions about their

care, and treatment options had been explained to them. They said they did not feel rushed and staff made time to listen to them. Feedback on the CQC comment cards gave examples which evidenced this.

The staff we spoke with demonstrated how alerts were placed on the computer system to identify patients who may be vulnerable. This included people who had dementia, learning difficulties and long term conditions. We saw records where patients had nominated others to be involved in discussions regarding their care if they lost the ability to communicate or make decisions for themselves.

Staff showed us consent forms which detailed the side effects and dangers of procedures. These documents recorded patients' consent and provided information on procedures. We saw examples of when a patient's consent had been sought and information provided to assist patients in making an informed choice on treatment.

The national patient survey information we reviewed showed 58% of practice respondents felt the GP involved them in care decisions and 74% felt the GP was good at explaining treatment and results. Both these results were below the weighted CCG regional average. Staff told us that these figures had been discussed at the practice meetings and GPs had reflected on their own practice. All staff were committed to improving these figures. Staff confirmed that the patient always had a choice for example which hospital to attend to see a specialist.

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.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a multidisciplinary team (MDT) approach with district nurses, palliative care nurses and hospital and hospice staff. We saw that the Gold Standard Framework (GSF) palliative care meetings were held and recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they chose.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

One of the GPs we spoke with told us about the emotional support the practice provided to patients and carers. The GP detailed the actions they took to provide support to patients and carers who had experienced bereavement. We saw examples of when patients and their carers had been supported and referrals made to other services that could provide specialist emotional support to them.

During the inspection we spoke with a mental health worker who had professional knowledge of working with the practice, although was not employed by them. This individual described positive support that practice staff had provided. We were given an example of when practice staff had stayed beyond their working hours to offer emotional support to a patient with emotional difficulties. This demonstrated a positive and caring approach and culture to meet the individual needs of the patients.

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 patients' 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. The practice used a risk tool which helped GPs detect and prevent unwanted outcomes for patients. This helped to profile patients by determining their level of risk dependent on the complexity of their disease type or needs.

The NHS Local Area Team (LAT) 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. We saw minutes of meetings where this had been discussed. We saw that actions had been agreed to implement service improvements and manage delivery challenges to its population. For example the high number of attendances at the hospital accident and emergency department.

Longer appointments were available for patients who needed them, for example those who were supported by an interpreter and those with long term conditions. This also included appointments with a named GP or nurse.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). One example of this was the introduction of a call back system where GPs can ring patients back rather that the patient attending an appointment. This was set up following patient feedback about having difficulty getting an appointment.

The practice had achieved and implemented the Gold Standards Framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. For example with a palliative care co-ordinator and district nurses.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. For example those with a learning disability and carers. The practice had access to translation and interpreting services and longer appointments were provided for those patients who were supported by an interpreter.

Female GPs worked at the practice and were able to support patients who preferred to have a female doctor. This reduced any barriers to care and supported the equality and diverse needs of the patients.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties. All treatment and consulting rooms for patients were located on the ground floor.

The practice had recognised the needs of different groups in the planning of its services, for example for carers and vulnerable people who were at risk of harm. The computer system used by the practice alerted GPs if patients were identified as at risk of harm, or if a patient was also a carer. We saw that specific information was provided to these patients to ensure they understood the various avenues of support available to them should they need it.

Access to the service

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were available from 8:00am to 6pm on weekdays and the practice offered additional appointments once per week from 6.30pm to 8.30pm. Patients with work commitments told us this was extremely helpful.

The practice had an online booking system which patients told us was easy to use. The practice also provided text message reminders for appointments and test results, and online or telephone consultations for patients where appropriate.

Patients were generally satisfied with the appointments system. 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. Five patients who completed CQC comment cards said that they had difficulty getting through on the telephone in the morning to make an appointment. The national GP survey for 2013 showed that this was an issue and only 44% of those who responded said they found it easy to get through to the practice by phone. The practice were aware of this issue and had taken steps to try to improve this for patients. This included the introduction of a new appointments system and a telephone call back facility. We saw evidence that the appointments system was frequently monitored to check how it was working and a follow up survey had been proposed by the patient participation group (PPG). This was to check if patients felt that the changes made had improved access to the appointments system. We saw that a follow up survey had been agreed by the practice management team.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. A complaints leaflet was available in the waiting area and details about how to make a complaint was set out on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last twelve months and found each were handled in a satisfactory and timely manner. The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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 did not have a formal written strategy to deliver high quality care and promote good outcomes for patients. However the practice had a statement of purpose which set out its vision and values and included a number of aims such as to: "ensure high quality, safe and effective medical care. We will continually strive to improve services for our patients". We spoke with the practice manager about the values and they confirmed that these were discussed at induction, at meetings with staff and during appraisals. The practice manager told us that they were intending to put the values into the induction pack for all new staff.

We spoke with six members of staff and they all knew or demonstrated the values of the practice and what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff from any computer within the practice. We looked at 10 of these policies and procedures and saw that staff were required to sign a statement to confirm they had received them. The statement identified where staff could access the policies and should keep up to date with the current versions. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

The practice held weekly practice meetings where all areas of governance were considered. We looked at minutes from the previous two meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF rewards practices for providing quality care and helps fund further improvements. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was monitored weekly and action taken to maintain or improve outcomes. For example we saw that the practice had taken action to try to reduce increased attendance levels of children from their patient group at the local accident and emergency department.

The practice had completed a number of clinical audits, for example a diabetes audit and an audit of specific drugs used for the treatment of depression. The audits identified the expected improvements from changes to practice and a follow up audit had either been carried out or planned at a later date to assess the progress and impact for patients.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk assessment folder which addressed a wide range of potential issues such as health and safety and security. We saw that identified risks were regularly discussed at team meetings and updated in a timely way. We saw evidence of prompt action taken recently to reduce a possible risk in relation to the plumbing system. This had been documented well and resolved quickly.

Leadership, openness and transparency

We saw that there was a leadership structure which had named members of staff in lead roles. For example the clinical manager was the lead for infection control, one GP was the lead for minor surgery and the urgent care lead on the Clinical Commissioning board. Another GP was heavily involved in the development of a Federation. This is where a group of GP practices come together to provide and develop some services jointly. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw evidence that practice meetings took place weekly. Staff told us that team meetings took place as and when needed. When information was passed to staff, they were required to sign to say that they had received the information. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time.

The practice manager had overall responsibility for the human resource policies and procedures. We reviewed a number of policies, for example a recruitment and induction policy which was in place to support staff. We were shown the employee handbook that was available to all staff and saw that it included sections on equal opportunities, personal harassment and welfare and hygiene. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

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

The practice gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at patient surveys and complaints made by the patients. We saw that positive action had been taken in response to these. For example we saw evidence where policies had been reviewed and updated following concerns regarding third parties, such as a solicitor requesting information about a patient.

The practice had an active patient participation group (PPG) which met every two months. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. We saw that the PPG at the practice carried out a number of surveys each year. One of the most recent surveys completed was to assess the success of a new telephone appointment/contact system that had been introduced in 2013 in response to issues regarding telephone access for patients. We saw that the results of this survey and actions agreed were available on the practice website.

The vice chair of the PPG told us that the group had been trying to recruit members from all age groups and backgrounds in order for them to be representative of the practice population. The group had arranged for posters about the PPG to be translated into different languages. Other posters had been redesigned to encourage interest in younger adults. We found that the PPG was proactively displaying posters in schools and local community groups too.

The practice had gathered feedback from staff through staff surveys, meetings, appraisals and discussions. We saw that staff had been surveyed regarding the appointment system, in addition to patients. The practice had a whistle blowing policy which was available to all staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff records and saw that regular appraisals took place which included agreed performance objectives and an individual training and development plan. Staff told us that the practice was very supportive of training. Records we checked showed that all mandatory training for staff was up to date and other relevant training was also provided.

We saw evidence of a robust induction plan and training logs for staff which included training competency assessments to ensure staff were proficient from their learning. All new staff were subjected to a review three to six month after commencing work at the practice. Records showed that this process was well documented and managed.

The practice had provided student nurse placements for a number of years. We saw that two of the student nurses included in this initiative had been employed as practice nurses at Carlton Street.

Carlton Street surgery was successful in bidding for additional funding to implement a new initiative developed by the local area team (LAT). This involved the practice making a commitment to employing and developing newly qualified nurses and also nurses new to practice nursing. This was a proactive approach to begin to address the anticipated future skill gaps in the workforce. We saw evidence that a structured framework had been set up for a newly qualified nurse accepted by the practice. This included extensive mentorship, clinical supervision and support with protected learning time included. Staff told us that Public Health England had shown great interest in how the initiative was working at the practice. The clinical manager had been invited as a guest speaker at key events to share their experience and progress of the scheme to encourage other practices to engage with the student placement scheme.

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. For example, the practice had identified a system issue around communication in relation to progressing an urgent request for a patient to have an electrocardiogram (ECG). An electrocardiogram is a simple, painless test that records the heart's electrical activity. We saw that the issue had been discussed at a team meeting and retraining had been provided for reception staff to improve this type of situation in the future. It was also agreed that GPs at the practice

Are services well-led?

Good

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

took a more proactive role. This demonstrated that the practice staff worked together to resolve problems and reviewed performance regularly to continually improve the quality of the service.

We saw that the practice had taken action to try to reduce the numbers of attendances at the hospital's accident and emergency department by children in their patient population group during the winter months of 2013/2014. The campaign for this was called Choose Well and the practice manager had worked in conjunction with a neighbouring practice to promote the scheme with local schoolchildren and their families. This involved staff from the practices, including a GP, visiting the school to discuss how best to deal with childhood illnesses. The impact of this was due to be monitored over the forthcoming winter season to see if it had any reduction on the numbers of children attending the hospital's accident and emergency department. This demonstrated a proactive and joined up approach to resolving a local problem.