

# Lattimore 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

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Lattimore Surgery on 9 December 2015. The practice achieved an overall rating of good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Systems were in place to identify and respond to concerns about the safeguarding of adults and children.
- We saw patients receiving respectful treatment from staff. Patients felt they were seen by friendly and helpful staff. Patients reported feeling satisfied with the care and treatment they received.

- The practice offered a number of services designed to promote patients' health and wellbeing and prevent the onset of illness.
- The practice acted upon best practice guidance to further improve patient care.
- The management and meeting structure ensured that appropriate clinical decisions were reached and action was taken.
- The practice appeared clean and infection control processes were adhered to.
- Systems were in place and adhered to for the appropriate management of medicines.

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

The provider should:

- Ensure that refrigerated medicines and vaccines are stored in accordance with the relevant guidance.
- Ensure that the clinical waste bins outside the practice are appropriately secured.

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?

The practice is rated as good for providing safe services. There were incident and significant event reporting procedures in place and action was taken to prevent recurrence of incidents when required. The structure of management communications ensured that staff were informed about risks and decision making. Systems were in place to identify and respond to concerns about the safeguarding of adults and children. Systems to ensure that medicines were checked, stored securely and managed appropriately were adhered to. The practice appeared clean. Systems to protect people from the risks of infection were in place and well adhered to at the practice. The medical equipment at the practice was fit for purpose and received regular checks for accuracy. Systems to ensure that staff employed at the practice received the relevant recruitment checks including criminal records checks were in place. Arrangements were in place for the practice to respond to foreseeable emergencies.

Good



### Are services effective?

The practice is rated as good for providing effective services. The practice reviewed, discussed and acted upon best practice guidance to improve the patient experience. There was a limited programme of repeated (full cycle) clinical audit at the practice to further improve patient care and the practice was working on developing this further. The practice provided a number of services designed to promote patients' health and wellbeing. The practice took a collaborative approach to working with other health providers and there was multi-disciplinary working. Clinical staff were aware of the process to obtain patient consent and were informed and knowledgeable on the requirements of the Mental Capacity Act (2005). A system to ensure all staff received an appraisal of their skills, abilities and development requirements was in place. The practice was proactive in ensuring staff learning needs were met.

Good



### Are services caring?

The practice is rated as good for providing caring services. On the day of our inspection we saw staff interacting with patients in reception and outside consulting rooms in a respectful and friendly manner. There were a number of arrangements in place to promote patients' involvement in their care. Accessible information was provided to help patients understand the care available to them. Patients told us they felt listened to and included in decisions about their care. They said they were treated with dignity and respect and were positive about staff behaviours.

Good



# Summary of findings

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services. There were services targeted at those most at risk such as older people and those with long-term conditions. As far as reasonably practicable the premises and services were adapted to meet the needs of people with disabilities, mobility issues and other impairments. At the time of our inspection appointments, including those required in an emergency were available. The practice used a number of methods to ensure patients had access to resources and information. Methods were available for patients to leave feedback about their experiences. The practice demonstrated it responded to patients' comments and complaints and where possible, took action to improve the patient experience.

Good



## Are services well-led?

The practice is rated as good for being well-led. The management and meeting structure ensured that clinical decisions were reached and action was taken. There was a process in place for identifying and managing risks and ensuring these were acted upon. There were named members of staff in lead roles and they demonstrated a good understanding of their responsibilities. Staff were supported by a system of policies and procedures that governed activity. Staff felt engaged in a culture of openness and consultation. The practice sought feedback from patients and staff and listened to representatives of the patient population.

Good



# 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

The practice is rated as good for the care of older people. The practice offered personalised care to meet their needs. Older patients had access to a named GP, a multi-disciplinary team approach to their care, home visits when needed and targeted immunisations such as the flu vaccine. A range of enhanced services were provided such as those for end of life care.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The practice provided patients with long-term conditions with an annual review to check their health and medication needs were being met. All newly diagnosed patients with diabetes were managed in line with an agreed pathway. Patients with long-term conditions had access to a named GP and targeted immunisations such as the flu vaccine. There were GP and nurse leads for a range of long-term conditions.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and protecting patients at risk of abuse. There were six week post-natal checks for mothers and their children. Programmes of cervical screening for women over the age of 25 and childhood immunisations were available to respond to the needs of these patients. Appointments were available outside of school hours. A range of contraceptive and family planning services were available. The premises was suitable for children and babies.

Good



### Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students). The practice offered online services such as appointment booking and repeat prescriptions. There was additional out of working hours access to meet the needs of working age patients. There was extended opening at The Village Surgery on Monday until 8.45pm. Routine health checks were available for patients between 40 and 74 years old. The practice encouraged feedback and participation from patients of working age through the virtual patient participation group (an online community of patients who work with the practice to discuss and develop the services provided).

Good



# Summary of findings

## People whose circumstances may make them vulnerable

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 learning disabilities. Patients with a learning disability received an annual health review and there was a GP lead for these patients. The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice maintained a register of patients who were identified as carers and additional information was available for those patients. There was a nominated carers' champion to provide carers with a first point of contact in the practice. Staff knew how to recognise signs of abuse in vulnerable people and were aware of their responsibilities in raising safeguarding concerns. The practice tackled inequity by identifying and addressing the specific needs of patients and enabling their full access to services.

Good



## People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. Patients experiencing dementia also received a care plan specific to their needs and an annual health check. A mental health trust well-being worker was based at the branch surgery once each week and patients could be referred to them by the GPs. There were GP leads for mental health, dementia and depression.

Good



# Summary of findings

## What people who use the service say

During our inspection, we spoke with three patients, reviewed five comment cards left by them and spoke with two representatives of the virtual patient participation group (vPPG). The vPPG is an online group of patients who work with the practice to discuss and develop the services provided.

Patients told us that the care and treatment they received at the practice was good. Patients said they felt staff were friendly and helpful and that their privacy and dignity was respected. They told us they felt listened to by the GPs and involved in their own care and treatment.

The results of the national GP survey for 2015 showed that 91.3% of the 101 respondents felt the GPs at the practice displayed care and concern towards them. The national average was 85.1%. For the nurses, this figure rose to 91%, also above the national average of 90.4%.

The friends and family test results from November 2015 showed that both of the two respondents were extremely likely to recommend the practice to friends and family if they needed similar care or treatment.

Patients told us that appointments were available and access to the practice by phone was good. Results from the national GP patient survey in 2015 showed that of the 101 respondents, 73.4% felt their experience of making an appointment was good. This was fractionally above average when compared to the rest of England (73.3%). When asked if their last appointment was convenient, 93.5% of respondents thought it was. This was also above average when compared to the rest of England (91.8%).

## Areas for improvement

### Action the service **SHOULD** take to improve

Ensure that refrigerated medicines and vaccines are stored in accordance with the relevant guidance.

Ensure that the clinical waste bins outside the practice are appropriately secured.

# Lattimore Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP and a nurse acting as specialist advisers.

## Background to Lattimore Surgery

Lattimore Surgery provides a range of primary medical services from its premises at Lattimore Surgery, 1 Upton Avenue, St Albans, Hertfordshire, AL3 5ER and The Village Surgery, 283 The High Street, London Colney, St Albans, Hertfordshire, AL2 1EU. We inspected both practices.

The practice serves a population of approximately 8,800. The area served is less deprived compared to England as a whole. The practice population is mostly white British with some Asian communities including those from a Bangladeshi background. The practice serves a slightly above average population of those aged from 0 to 9 and 30 to 49. There is a lower than average population of those aged between 20 and 24 and 65 and older.

The clinical team includes one female and three male GP partners, two female salaried GPs and three female practice nurses. The team is supported by a practice manager and 16 other administration, reception and secretarial staff. The practice is on a GMS contract.

Lattimore Surgery is staffed with the phone lines open from 8am and doors open from 8.30am to 6.30pm Monday, Wednesday and Friday. On Tuesdays and Thursdays the doors close at 5pm with the phone lines transferred to The

Village Surgery, open until 6.30pm on those days. The Village Surgery is staffed with the phone lines open from 8am and the doors open from 8.30am to 6.30pm Monday to Friday with extended opening every Monday until 8.45pm.

Appointments are approximately from 8.30am to midday and 3.30pm to 6pm daily, with slight variations depending on the doctor and later opening every Monday. An out of hours service for when the practice is closed is provided by Herts Urgent Care.

## Why we carried out this inspection

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

We carried out a comprehensive inspection of this practice 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). Also, to look at the overall quality of the service and to provide a rating for the practice under the Care Act (2014).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

## How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. We carried out



# Detailed findings

an announced inspection on 9 December 2015. During our inspection we spoke with a range of staff including three GP partners, two practice nurses, the practice manager and members of the reception and administration team. We spoke with three patients and two representatives of the virtual patient participation group (the vPPG is an online group of patients who work with the practice to discuss and develop the services provided). We observed how staff interacted with patients. We reviewed five CQC comment cards left for us by patients to share their views and experiences of the practice with us.

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

- Is it safe?
- Is it effective?
- Is it caring?

- Is it responsive to people's needs?
- Is it well-led?

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

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

# Are services safe?

## Our findings

### Safe track record

The staff we spoke with demonstrated an understanding of their roles in reporting incidents and significant events and were clear on the reporting process used at the practice. The senior staff understood their roles in discussing, analysing and reviewing reported incidents and events.

The weekly education meeting was used for senior staff to review and take action on all reported incidents and events. The records we looked at demonstrated the practice had managed these consistently over time. The staff we spoke with who attended the meeting were all able to recount the details of recent incidents and events discussed. All staff directly involved in specific incidents and events said they were kept informed and updated of related discussions, learning and action points. Details of any discussions and decisions made in the meetings were made available to all staff through a range of team conversation with senior staff, update emails and other staff meetings.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and taking action on incidents and significant events. Significant event analysis is used by practices to reflect on individual cases and where necessary, make changes to improve the quality and safety of care. We looked at examples of how the procedure was used to report incidents and significant events relating to clinical practice and other issues. From our conversations with staff and our review of documentation we found that incidents and events were discussed as required at weekly education meetings. This included discussion on how the incidents could be learned from and any action necessary to reduce the risk of recurrence. We saw that the practice documented all reported incidents and events which included a record of the learning points, the action taken to prevent recurrence and the reviewed effectiveness of that action.

Safety alerts were reviewed and distributed to the relevant staff by the practice manager. The staff we spoke with displayed an awareness of how safety alerts were communicated and told us they were receiving those relevant to their roles. They were able to give examples of recent alerts relevant to the care they were responsible for.

### Reliable safety systems and processes including safeguarding

There were systems in place for staff to identify and respond to potential concerns around the safeguarding of vulnerable adults and children using the practice. We saw the practice had safeguarding policies and protocols in place and one of the GP partners was the nominated lead for safeguarding issues. The staff we spoke with demonstrated a clear knowledge and understanding of their own responsibilities, the role of the lead and the safeguarding processes in place. From our conversations with them and our review of training documentation, we saw that almost all staff had received safeguarding and child protection training at the level required for their roles. A programme was in place to ensure all staff completed the training.

We spoke with staff about safeguarding concerns raised at the practice. Their responses demonstrated that they followed agreed policies and protocols. All the relevant agencies were informed and involved. Identifying symbols were used on patients' notes to inform staff they were considered to be at risk. All patients of concern including those with safeguarding issues were discussed at regular meetings. This involved a multi-disciplinary team including external healthcare professionals.

From our conversations with staff and our review of training documentation we found that reception staff at the practice were trained to be a chaperone (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). However, the practice had recently stopped all non-clinical staff without a criminal records check from completing chaperone duties and the practice policy was amended accordingly. Only nursing staff were completing chaperone duties. The nursing staff we spoke with understood their responsibilities when acting as chaperones and a practice policy was in place to guide them in that role. We saw that all clinical staff had received a criminal records check.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take

## Are services safe?

in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. However, we found that the refrigerator at The Lattimore Surgery was so full that stock was stored on the bottom level. This was not in accordance with relevant guidance.

We saw the system in place to record the amount and type of medicines (including vaccines) kept at the practice was well adhered to. Processes were in place to check medicines were within their expiry dates 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Processes were in place and followed to ensure hand written and computer generated prescription forms were tracked and kept securely at all times.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged and reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

### Cleanliness and infection control

We saw that the practice appeared clean. We saw there were cleaning schedules in place and the cleaning records we looked at demonstrated these were adhered to. Hand wash facilities, including hand sanitiser were available throughout the practice. There were appropriate processes in place for the management of sharps (needles) and clinical waste. However, the external clinical waste bins were not appropriately secured.

The practice had a comprehensive policy and protocols on infection control issues. From our conversations with staff and our review of documentation we found that staff received infection control training. All the staff we spoke with were knowledgeable about infection control processes at the practice. The practice had a nominated lead for infection control issues. The lead was clear on their additional responsibilities and staff were clear on who the lead was.

A documented audit of cleanliness and infection control issues at the practice was completed in November 2015. We saw that where actions were required these were completed and recorded. Infection control processes were well adhered to at the practice.

A Legionella risk assessment (Legionella is a term for particular bacteria which can contaminate water systems in buildings) completed at the practice in September 2012 identified some risks. We saw the practice had responded by completing some of the necessary actions and maintained records to demonstrate this. Where actions were not completed, the practice had risk assessed why this was not necessary.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw documentary evidence of the annual calibration of medical equipment to ensure the accuracy of measurements and readings taken. All of the equipment we saw during our inspection appeared fit for purpose. All portable electrical equipment was routinely tested and the relevant report was available to demonstrate this.

### Staffing and recruitment

The staff we spoke with understood what they were qualified to do and this was reflected in how the practice had arranged its services. The practice had calculated minimum staffing levels and skills mix to ensure the service could operate safely. The staffing levels we saw on the day of our inspection met the practice's minimum requirement and there was evidence to demonstrate the requirement was regularly achieved.

We looked at six staff records. They contained evidence that the appropriate recruitment checks such as satisfactory evidence of conduct in previous employment and photographic identification were undertaken prior to employment. All clinical staff had received a criminal records check. Following a recent change to policy, non-clinical staff trained as chaperones were not able to undertake those duties unless first agreeing to and completing a criminal records check.

### Monitoring safety and responding to risk

There were systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to

## Are services safe?

the practice. These included dealing with emergencies, medicines management, infection control, medical equipment and the health and safety (including fire safety) of the environment, staff and patients.

The staff we spoke with demonstrated a good understanding of their roles and responsibilities towards health and safety, fire safety and dealing with emergencies among other things. Our review of documentation showed these issues were part of the induction process and essential training requirement for all staff and that appropriate policies and risk assessments were available. Action was taken on risk recommendations made by external contractors and safety services.

The weekly education and practice meetings were used for senior staff to review and take action on all reported risks, incidents and events. Details of any discussions and decisions made in those meetings were made available to all staff through a range of team conversation with senior staff, update emails and other staff meetings.

### **Arrangements to deal with emergencies and major incidents**

The practice had procedures in place to respond to emergencies and reduce the risk to patients' safety from such incidents. We saw that the practice had a business continuity and disaster recovery policy in place. This covered the emergency measures the practice would take to respond to any loss of premises, records and utilities among other things. The relevant staff we spoke with understood their roles in relation to the contingency plan.

There was documentary evidence to demonstrate that almost all members of staff at the practice had completed cardiopulmonary resuscitation (CPR) training. A programme was in place to ensure all staff completed the training. The practice provided emergency medical equipment that was easily accessible to staff. We looked at the emergency medical equipment and medicines available at the practice including oxygen and a defibrillator. All of the equipment and emergency medicines were within their expiry dates. Documented checks on the equipment were available and completed regularly.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice reviewed, discussed and acted upon best practice guidelines and information to improve the patient experience. A system was in place for National Institute for Health and Care Excellence (NICE) guidelines to be distributed and reviewed by clinical staff.

Staff demonstrated how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

A coding system was used to ensure the relevant patients were identified for and allocated to a chronic disease register and the system was subject to checks for accuracy. Once allocated, each patient was able to receive the appropriate management, medication and review for their condition.

The GPs told us they led in specialist clinical areas such as cancer, diabetes, depression and coronary heart disease. The nurses supported this work and had their own areas of lead responsibility including patients with asthma and chronic obstructive pulmonary disease. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

### Management, monitoring and improving outcomes for people

The practice had a limited system in place for completing repeated (full cycle) clinical audit. Clinical audit is a way of identifying if healthcare is provided in line with recommended standards, if it is effective and where improvements could be made. Examples of clinical audits included those on the appropriate prescribing of certain antibiotics and the adequate recording of clinically significant information for two methods of contraceptive insertion and implant. We found the data collected from the audits had been analysed and clinically discussed and the practice approach was reviewed and modified as a result when necessary. Other clinical audits were available, but those that were repeated (full cycle) audits to demonstrate the effectiveness of any changes made were

limited. The practice had identified and acknowledged that its programme of repeated (full cycle) clinical audit was limited and we saw that action was being taken to rectify this.

The team was making use of clinical audit, clinical supervision and meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

The practice participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF). QOF is a national data management tool generated from patients' records that provides performance information about primary medical services.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. It achieved 90.3% of the total QOF target in 2014/2015 with 9.3% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The QOF achievement was 5.8% below the local clinical commissioning group (CCG) average and 3.2% below the national average.

For asthma, the practice achieved 100% of the target in 2014/2015. This was 0.9% above CCG average and 2.6% above the national average. For hypertension, the practice also achieved 100% of the target in 2014/2015. This was 1.4% above CCG average and 2.2% above the national average. There were other areas of 100% and above CCG and national average performance including chronic obstructive pulmonary disease and atrial fibrillation.

For diabetes, the practice achieved 66.3% of the target in 2014/2015. This was 24.6% below CCG average and 22.9% below the national average. We discussed this area of below CCG and national average performance with senior staff during our inspection. We found the practice was aware of its performance in this area and the reasons for this, some of which were beyond its control. Where the practice was able to influence its performance in this area it had taken steps to rectify this.

### Effective staffing

# Are services effective?

## (for example, treatment is effective)

From speaking with staff and our review of documentation we found that staff received an appropriate induction when joining the service. Where applicable, the professional registrations of staff at the practice were up-to-date. All the GPs had been revalidated or had a date for revalidation and as part of this process, the relevant professional bodies check the fitness to practise of each individual.

We saw that a system of essential training (training that each staff member is required to complete in accordance with the practice's own requirements) was in place for staff. Our review of training records showed that most staff had completed most of the training within the required timescales. A programme was in place to ensure all staff completed the required training.

Practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, all the relevant nurses were up-to-date with cervical cytology training.

From our conversations with staff and our review of documentation we saw that some staff had received an appraisal of their performance and competencies in the past year. A programme was in place to ensure appraisals were completed for the remaining staff. We looked at some examples and saw that there was an opportunity for staff to discuss any learning needs. The staff we spoke with told us the practice was proactive in organising the required training to meet those needs.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. We saw that a system was in place for such things as patient blood and radiology results and pathology reports to be received electronically. These processes allowed for patients requiring follow up to be identified and contacted. A system was in place to ensure that in any GP's absence, the results were still reviewed and processed. All the staff we spoke with understood how the system was used and we saw this was working well.

The practice held multi-disciplinary team meetings to discuss the needs of complex patients. This included those with end of life care needs. The monthly meetings were attended by the GPs and community based healthcare

professionals such as district and hospice nurses to discuss palliative care (end of life), cancer and other high level care patients. We saw that the issues discussed and actions agreed for each patient were recorded.

### Information sharing

The practice used several processes and electronic systems to communicate with other providers. For example, there was a system in place with the local out of hours provider to enable patient data to be shared in a secure and timely manner. An electronic system was also in place for making referrals through the Choose and Book (e-Referral) system. 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.

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

### Consent to care and treatment

The clinical staff we spoke with demonstrated an understanding of the Mental Capacity Act (2005) and its implications for patients at the practice. From our conversations with them we found that patients' capacity to consent was assessed in line with the Mental Capacity Act (2005). Clinical staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity. They were also aware and demonstrated a good understanding of the Gillick competency test (a process to assess whether children under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge).

There was a practice process for documenting consent for specific interventions. The clinical staff we spoke with were clear on the process and when documented consent was required. We saw examples of documented patient consent for recent patient procedures completed at the practice.

### Health promotion and prevention

## Are services effective?

(for example, treatment is effective)

We saw that all new patients at the practice were offered a health check. This included a review of their weight, blood pressure, smoking and alcohol consumption. Routine health checks were also available for all patients between 40 and 74 years old. In the past 12 months 35 (1.26%) of the 2,780 eligible patients had received the check. The practice had identified the completion rate was very low. Senior staff told us that a plan was developed in discussion with the relevant agencies and authorities to considerably improve the completion of the health checks. For much of the period the practice participated in the programme there was a lack of the appropriate staff to complete the work. Partly in response to this, the practice had recently recruited a new nurse. Once fully trained, the nurse would be completing the checks.

We found that the practice offered a number of services designed to promote patients' health and wellbeing and prevent the onset of illness. We saw various health related information was available for patients in the waiting area and throughout the practice.

The practice had participated in targeted vaccination programmes for older people and those with long term conditions. These included the shingles vaccine for those aged 70 to 79 and the flu vaccine for children, people with long term conditions and those over 65. The practice had 1,164 patients aged over 65. Of those, 927 (79.6%) had received the flu vaccine in the 2014/2015 year.

Two nurses and two GPs at the practice were trained to provide and carry out cervical cytology. They had all completed their update training. A system of alerts and recalls was in place to provide cervical screening to women aged 25 years and older. At the time of our inspection, the current practice data showed there was a 76.7% take up rate for this programme over the past five years (1,637 out of 2,133 eligible patients). For the 2014/2015 year the practice achieved 100% of the total QOF target for cervical screening. This was 1.3% above the clinical commissioning group (CCG) average and 2.4% above the national (England) average.



# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

During our inspection we saw that staff behaviours were respectful and professional. We saw examples of reception staff being helpful and courteous to patients attending the practice. We saw the clinical staff interacting with patients in the waiting areas and outside clinical and consulting rooms in a friendly and caring manner. All staff spoke quietly with patients to protect their confidentiality as much as possible in public areas.

We spoke with three patients on the day of our inspection, all of whom were positive about staff behaviours and the good clinical care they felt they received. They said they felt treated with dignity and respect by staff at all times. A total of five patients completed CQC comment cards to provide us with feedback on the practice. All of the responses received about staff behaviours were positive. They said staff were friendly and helpful and treated them with dignity and respect.

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

### Care planning and involvement in decisions about care and treatment

The practice had made suitable arrangements to ensure that patients were involved in and able to participate in decisions about their care. The three patients we spoke with said they felt listened to and had a communicative relationship with the GPs and nurses. They said their questions were answered by the clinical staff and any concerns they had were discussed. We also read comments left for us by five patients. Of those who commented on how involved they felt in their care and the explanations they received about their care, all of the responses were positive.

The results of the national GP survey for 2015 showed that 82.8% of the 101 respondents felt the GPs at the practice were good at involving them in decisions about their care.

The national average was 81.4%. The GPs were considered to be good at listening by 96.2% of patients who responded. This was also above the national average of 88.6%.

### Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey for 2015 showed that 91.3% of the 101 respondents felt the GPs at the practice displayed care and concern towards them. The national average was 85.1%. For the nurses, this figure rose to 91%, also above the national average of 90.4%. The feedback we received during our conversations with three patients and review of the comments left for us by five patients was consistent with the survey response.

All patients receiving palliative care were discussed at monthly multi-disciplinary team meetings. We saw that the practice maintained a record of all recent patient deaths and these patients were also discussed at the monthly meeting. From speaking with staff, we found there was no practice wide process for approaching recently bereaved patients. Each GP was responsible for approaching patients individually. The GPs we spoke with gave mixed responses on whether and how they made contact with the family of each deceased patient offering an invitation to approach the practice for support.

The senior staff we spoke with knew of the availability of a local counselling service (including bereavement counselling) and the practice referred patients requiring such support to them. A mental health trust well-being worker was based at the branch surgery on a Wednesday each week. Patients could access this service to obtain counselling and advice through referral from the GPs.

Patients in a carer role were identified where possible. The practice maintained a register of 118 patients (approximately 1.3% of the patient list) who were identified as carers. This information was mainly sourced from patients upon registering with the practice or during their consultations with the GPs. Staff told us those patients on the register had access to an annual health review and home visits including vaccinations at home if required. The practice manager was the nominated carers' champion to provide carers with a first point of contact in the practice.



## Are services caring?

We saw information aimed at carers provided on the practice's website and displayed in the waiting areas. This gave details of the local support available among other things.

# 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 provided an enhanced service in an effort to reduce the unplanned hospital admissions for vulnerable and at risk patients including those aged 75 years and older. Enhanced services are those that require a level of care provision above what a GP practice would normally provide. As part of this, each relevant patient received a care plan based on their specific needs, a named GP and an annual review. At the time of our inspection, 148 patients (2.15% of the practice's patient population over 18) were receiving such care. There was also a palliative care register of 12 patients at the practice with regular multi-disciplinary meetings to discuss those patients' care and support needs.

Smoking cessation services including advice were provided at the practice by two qualified nurses. There were 1,597 known smokers in the practice patient population. Of those 1,139 were offered intervention and given advice on smoking cessation. At the time of our inspection, 89 patients were being seen by the smoking cessation advisers (nurses).

We saw that all newly diagnosed patients with type two diabetes were referred for diabetic eye screening and to the DESMOND programme in adherence with National Institute for Health and Care Excellence (NICE) guidelines. DESMOND is an NHS training course that helps patients to identify their own health risks and set their own goals in the management of their condition.

There were six week post-natal checks for mothers and their children. A range of contraceptive and family planning services were available at the practice. Counselling services were available for patients with mental health issues and there was a GP lead for those patients.

The practice had a virtual patient participation group (vPPG). The vPPG is an online community of patients who

work with the practice to discuss and develop the services provided. From our conversations with vPPG members it was clear there was some engagement between the group and the practice.

### Tackling inequity and promoting equality

We found that most staff at the practice had completed equality and diversity training. We saw that as far as was reasonably practicable the premises and services were adapted to meet the needs of people with disabilities. There was step free access to both premises. We saw that clinical services were provided on the ground and first floors at both Lattimore Surgery and its branch The Village Surgery. There was no lift at either practice. The staff we spoke with said patients with disabilities including mobility issues were seen in the ground floor consulting rooms where possible. We saw that a system was in place to identify patients who use wheelchairs or with other mobility issues and ensure they were seen in ground floor consulting rooms. They were seen at The Village Surgery where possible, as disabled parking and accessible toilet facilities were available there. This was promoted on the practice's website.

An external translation service was available to the practice. This was mainly used at The Village Surgery for languages including Bengali and Polish. Hearing loops were provided at both reception areas for those patients who may need it and staff were aware of how to book a signing interpreter. One of the GPs was fully competent in sign language. There were male and female GPs in the practice and patients could choose to see a male or female doctor.

### Access to the service

On the day of our inspection we checked the appointments system and found the next advance release routine bookable appointment to see any of the three GP partners we checked was within one working day. Another was available in three working days. Further same day and 48 hour advance release appointments would also be made available for each GP over that period. We saw that the appointments system was structured to ensure that GPs were able to complete home visits every day. The system ensured that all urgent cases were seen on the same day and each GP was able to complete telephone consultations.

# Are services responsive to people's needs?

## (for example, to feedback?)

The phone lines at both the Lattimore and Village surgeries were staffed and open from 8am. The Lattimore Surgery's doors were open from 8.30am to 6.30pm Monday, Wednesday and Friday. On Tuesdays and Thursdays the doors closed at 5pm with the phone lines transferred to the branch Village Surgery, open until 6.30pm on those days. The Village Surgery's doors were open from 8.30am to 6.30pm Monday to Friday. There was extended opening at The Village Surgery on Monday until 8.45pm. This provided some additional access to the practice for those who found attending in normal working hours difficult.

Information was available to patients about appointments on the practice website. This included how to book appointments through the website. Patients were able to make their repeat prescription requests at the practice or online through the practice's website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out of hours (OOH) service was provided to patients.

We saw there was a standard process in place for the practice to receive notifications of patient contact and care from the out of hours provider. We saw evidence that the practice reviewed the notifications and took action to contact the patients concerned and provide further care where necessary.

During our inspection, we spoke with three patients and read the comments left for us by five patients. Of those who commented on the appointments system and access to the practice by telephone all of the responses were positive. Patients told us that appointments were available.

Results from the national GP patient survey in 2015 showed that 66.9% of patients felt they did not have to wait too long to be seen at the practice. This was above average when compared to the rest of England (57.7%). Of the 101 respondents, 73.4% felt their experience of making an

appointment was good. This was fractionally above average when compared to the rest of England (73.3%). When asked if their last appointment was convenient, 93.5% of respondents thought it was. This was also above average when compared to the rest of England (91.8%).

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. During our inspection we saw there was a complaints procedure available and there were two designated responsible persons who handled all complaints in the practice. These were the practice manager and one of the GP partners. Those two individuals dealt with all aspects of complaints made to the practice. Both the practice and education meetings were used as required for senior staff to discuss and take action on all reported complaints.

We saw that information was available to help patients understand the complaints system. A leaflet containing information on how to complain was available from reception. All of the staff we spoke with were aware of the process for dealing with complaints at the practice. During our inspection we spoke with three patients, none of whom had ever needed to make a complaint about the practice.

We looked at the practice's records of complaints from 2014/2015. We saw examples of when the complainants were contacted to discuss the issues raised. As a result, the practice had agreed actions to resolve the complaints to their satisfaction. We saw that where necessary, actions were taken and the complainants formally responded to in writing in accordance with the practice's own procedure. The action and learning points for all the complaints received by the practice in the 2014/2015 year were documented in an annual review.

# 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

From speaking with staff and our review of documentation, we found the practice had a vision contained within its statement of purpose to listen and respond to patients, treating them equally and with respect by providing an accessible and professional service. The practice aimed to provide high quality medical care whilst respecting the needs of individual patients.

The main strategic focus of the practice in 2014/2015 was staff development. The practice's staff development plan reviewed the distribution of tasks completed in the practice among the roles available to identify if additional resources were required. The analysis concluded more nursing staff were required and by the end of 2015 more nursing staff were recruited. During 2015, the practice had also commenced plans to procure and develop new premises. This was ongoing at the time of our inspection.

The weekly practice meeting attended by the GPs and the practice manager was used to discuss, implement and monitor the direction of the practice throughout the year. Discussions had and decisions made at those meetings were cascaded to staff through a range of team conversation with senior staff, update emails and other staff meetings.

Staff told us they were involved in discussions about the practice's direction and strategy. They said this made them feel valued and supported and provided them with the opportunity to discuss relevant issues that affected them as staff and also their patients.

### Governance arrangements

The practice had decision making processes in place. Staff at the practice were clear on the governance structure. They understood that the GP partners were the overall decision makers supported by the practice manager. There was a clear protocol in place for how decisions were agreed and the meeting structure supported this.

The practice had a system of policies and procedures in place to govern activity and these were available to all staff. All of the policies and procedures we looked at during our inspection were reviewed and up-to-date.

The practice had arrangements for identifying, recording and managing risks. The weekly practice and education meetings were used as required for senior staff to review and take action on all reported risks, serious incidents, significant events and complaints. This included discussion on how the incidents could be learned from and any action necessary to reduce the risk of recurrence. We looked at records that demonstrated this happened as and when required. Details of any discussions and decisions made in those meetings were made available to all staff through a range of team conversation with senior staff, update emails and other staff meetings. We saw that the practice documented all reported incidents and events which included a record of the learning points, the action taken to prevent recurrence and the reviewed effectiveness of that action.

### Leadership, openness and transparency

There was a clear leadership structure at the practice which had named members of staff in lead roles. We saw there were nominated GP leads for safeguarding, infection control and patients with learning disabilities, depression, cancer, dementia and coronary heart disease among others. There were also nurse led clinics for patients with asthma and chronic obstructive pulmonary disease. The leads showed a good understanding of their roles and responsibilities and all staff knew who the relevant leads were.

Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. All the staff we spoke with said they felt fortunate to be part of a supportive and friendly team.

From our conversations with staff and our review of documentation, we saw there was a regular schedule of meetings and protected learning at the practice for individual staff groups, multi-disciplinary teams and all staff to attend. Staff told us there was an open culture within the practice and they had the opportunity to raise and discuss issues at the meetings. They said they felt their views were respected and considered.

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

The practice had mechanisms in place to listen to the views of patients and those close to them. The practice had a virtual patient participation group (vPPG) of approximately 164 members. The vPPG is an online community of patients

# Are services well-led?

Good 

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

who work with the practice to discuss and develop the services provided. We saw that through email communication the group was able to feedback its views on a range of practice issues. We spoke with two members of the vPPG who said the group had good and open working relationships with practice staff. They said the vPPG was treated as a valuable resource by the practice. We saw the vPPG was integral in developing actions in response to the practice's last patient survey.

The practice had distributed its last patient survey in February 2015 and responses were received from 32 patients. In response to the survey, the vPPG worked with the practice to develop priority areas set out in their annual report for 2014/2015. These included improving access to the practice by telephone. As a result, the practice had recruited two new members of administration and reception staff during 2015 increasing the staff available to answer phones at busy periods in the mornings.

We saw that an online comments and suggestions facility was provided on the practice's website. Any comments and suggestions made were reviewed by the practice manager. We saw that when patients left their contact details the practice manager provided a response to all comments and suggestions received.

The staff we spoke with said patient feedback was discussed in their meetings and through general staff conversations so they were clear on what patients thought

about their care and treatment. They said the schedule of various practice and other staff meetings also provided them with an opportunity to share their views on the practice.

## Management lead through learning and improvement

Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Non-clinical staff also said their development was supported. We saw that protected learning time was used to provide staff with the training and development they needed to carry out their roles effectively.

From our conversations with staff and our review of documentation we saw that some staff had received an appraisal of their performance and competencies in the past year. A programme was in place to ensure appraisals were completed for the remaining staff. The examples we looked at showed these were an opportunity for staff to discuss any learning needs and their professional development. The staff we spoke with told us the practice was proactive in organising the required training to meet those needs.

A system was in place for senior staff to review and action all reported risks, incidents, events and complaints. The evidence we reviewed demonstrated that all incidents and events were discussed. This included discussion on how the incidents could be learned from.