

# The Globe Town 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 at Globe Town Surgery on 25 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, well-led, caring and responsive services. It was also good for providing services for the care of older people, those with long term conditions, families, children and young people, working age (including those recently retired and students), people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

The provider should:

- Ensure all staff complete infection control training;
- Develop the patient participation group to become more representative of the patient population.

**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. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to staff within the practice to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and managed. There was enough staff to keep patients safe. The practice had systems in place to ensure patients were safe including safeguarding and chaperone procedures. There was a process in place to effectively manage medicines, including monitoring correct storage of vaccines. Patients were treated in a clean environment and processes were in place to monitor cleanliness and infection control.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed that patient outcomes were above the average for the local Clinical Commissioning Group. For example, patients with diabetes who had a written care plan and attended an annual consultation in the last 15 months (89% compared to the local average of 82%), and the percentage of smoking patients that consented to intervention (96% for July 2014 compared to the local average of 84% for the same period). National Institute for Health and Care excellence (NICE) guidance was routinely referred to and used. People's needs were assessed and care was planned and delivered in line with current regulations. This included an assessment of capacity and the promotion of good health. Staff received appropriate training for the role they performed. However we found that staff had not undertaken training in infection control. Staff received annual appraisals and were encouraged to develop their skills and learning. We saw evidence of multi-disciplinary working. The practice was able to demonstrate completed audit cycles, where changes had been implemented and improvements made to improve health outcomes.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed patients ratings for the practice were higher than other practices within the local Clinical Commissioning Group for several aspects of care. For example 73% of patients said that the last GP they spoke with was good at treating them with care and concern, which was above the clinical commissioning group CCG average.

Good



# Summary of findings

The national GP patient survey 2014 showed that 100% of patients had confidence in the nursing staff, which was above the CCG average of 96%. Patients said that they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. We saw that staff treated patients with kindness and respect ensuring confidence was maintained.

## **Are services responsive to people's needs?**

The practice is rated as good for providing responsive services. The practice reviewed the needs of the local population and engaged with both the local CCG and practice network to secure service improvements where these were identified. Patients reported good access to the service at a time that suited them with emergency appointments available on the day. Patients were allocated a named GP and there was good continuity of care. The practice had accessible facilities and was well equipped to treat patients. There was an accessible complaints system with evidence demonstrating the practice responded quickly to issues raised. There was evidence of shared learning from complaints.

**Good**



## **Are services well-led?**

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver its services. Staff were clear about the vision and their responsibilities and were encouraged to be actively involved in the continued development of the vision and strategy. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern business activity and service delivery. Regular meetings to discuss and review governance and management issues had taken place. There was a system in place to identify and monitor risk to staff and patients. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group, but this was in need of further development to be more representative of the patient population.

**Good**



# Summary of findings

## What people who use the service say

During our inspection we spoke with ten patients at the surgery and collected eleven comment cards that had been completed by patients.

Patients were happy with the service provided and said that they were treated with respect and well cared for. Patients told us that they were involved in the decision making process regarding their treatment, and were given information about all the treatment options available to help them to make their choices.

Patients we spoke with who were receiving on going treatment were happy with the way their care was being managed and told us they were kept informed at all times.

We saw from the national GP patient survey 2014 that 96% of patients that completed the survey received an

appointment at a convenient time and 76% said that the GP's were good at explaining tests and treatments. The practice scored particularly well with 100% of the patients participating in the survey having confidence in the nurses. The Clinical Commissioning Group (CCG) average for this question was 93%. Areas which the practice had poorer scores included patients getting to speak to the GP of their choice (31% compared to the CCG average of 53%) and the overall experience of making an appointment (46% compared to the CCG average of 69%).

The main concern raised by patients was the telephone appointment system. This was in the process of being addressed by the practice through the implementation of a new telephone system.

## Areas for improvement

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

- Ensure all staff complete infection control training;
- Develop the patient participation group to become more representative of the patient population.

# The Globe Town Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP specialist advisor. Each member of the team was granted the same authority to enter the practice as the CQC lead inspector.

## Background to The Globe Town Surgery

Globe Town Surgery is located in the London Borough of Tower Hamlets. The practice is part of the NHS Tower Hamlets Clinical Commissioning Group (CCG) which is made up of 36 practices. It currently holds a Personal Medical Services contract and provides NHS services to 11,934 patients. The practice serves a diverse population with many patients for whom English is an additional language. The practice does not have a large older population with the majority of its patients being between the ages of 14 and 39. The practice is situated in its own premises owned by the NHS. Consulting rooms are on the ground floor, allowing easy access for patients with mobility issues. The practice's offices are on the second floor. There are currently seven GP's, a GP registrar, a practice nurse, two healthcare assistants and administrative staff. The practice is open for appointments between 8.45am and 6.30pm each weekday except Thursday, when the practice is closed between 2pm and 6.30pm. During the hours the practice was closed, specialised clinics operated between 2pm and 5pm. Appointments are offered on the day or within 48 hours.

Appointments could also be pre-booked up to one month ahead. The practice had opted out of providing an out of hour's service and refers patients to the local out of hour's service or the 'NHS 111' service.

The service is registered with the Care Quality Commission to provide the regulated activities of the treatment of disease, disorder or injury, family planning, maternity and midwifery services, diagnostic and screening procedures and surgical procedures.

The practice provides a range of services including child health and immunisation, smoking cessation and clinics for patients with long term conditions. The practice also provides a clinic at the local university for the large student population.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider has not been inspected before and that is why we included them.

## 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?

# Detailed findings

- 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations such as Healthwatch, NHS England and Tower Hamlets Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced inspection visit on 25 November 2014. During our visit we spoke with a range of staff, including GPs, the Practice Nurse and administrative staff, and spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experience of the service.

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as complaints and general comments 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, we found evidence of where a case of meningitis was reported within the student population registered with the practice. The incident was recorded and all measures taken to ensure patient safety, including contacting all students and offering a vaccination.

### Learning and improvement from safety incidents

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the last 12 months. This showed the practice had managed these consistently over time and could provide evidence of a safe track record over this period of time.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We viewed five records of significant events that had occurred during the last 12 months. Incidents were a fixed agenda item at weekly staff meetings. The practice had significant events meetings quarterly, with all staff being present, where events were discussed and appropriate learning took place. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and were encouraged to do so.

National Patient's Safety Alerts were disseminated by the practice manager to practice staff to be acted upon. For example, a recent alert for Ebola was discussed within the practice and used to promote staff's awareness.

### Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. We viewed the staff training records which showed that all staff had received relevant role-specific training on safeguarding. Staff knew how to recognise signs of abuse and their responsibilities to report concerns to relevant members of staff and external agencies. Contact details for these were easily accessible.

The practice had a dedicated lead for safeguarding vulnerable adults and children. Clinical staff had been trained to Level 3 in child protection and non-clinical staff to Level 1.

A chaperone policy was in place and on display throughout the practice. Patients were routinely offered a chaperone and if they declined, it was recorded in the patient notes. All staff had undertaken chaperone training and all staff undertaking chaperone duties had received a Disclosure and Barring Service (DBS) check. The practice currently had no male chaperones.

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

### Medicines management

The practice had a GP designated as lead for medicines management. We checked all medicines held at the practice. We found they were stored securely and only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures which was followed by staff. We found that vaccines were stored within the correct temperature range and the temperatures were checked daily.

A process was in place to check all medicines were within their expiry date. All medicines checked were within their expiry date and suitable for use. Expired medicines were disposed of in line with waste regulations. Vaccines were administered by the practice nurse in line with legal requirements and national guidelines.

There was a protocol for repeat prescribing which was in line with national guidance and followed by the practice. The protocol covered all areas including the production of the repeat prescription by administration staff, authorisation by the GP and how to manage any changes to prescription requests. All prescriptions were reviewed and authorised by the duty GP before issuing to the patient. This helped to ensure that patient prescriptions were always appropriate to patient need.



# Are services safe?

## Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules for each room which were fully completed. Patients we spoke with told us that they always found the practice clean and they had no concerns about cleanliness or infection control.

One of the GP partners was the lead on infection control. However, we found no evidence that staff had received infection control training relevant to their roles after initial induction training. We saw evidence that for the past two years that the practice had undertaken infection control audits, with appropriate action being taken and the results of the audits being discussed at team meetings.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement the control of infection measures. This was provided by the local Clinical Commissioning Group (CCG). It provided guidance on the use of personal protective equipment, cleaning portable equipment and the correct procedure for washing hands. There was also a policy for needle stick injury, which was available to all staff on the practice intranet and displayed within consulting 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 carried out regular tests in line with the policy to reduce the risk of infection to staff and patients.

## Equipment

Staff we spoke with told us that they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We were provided with evidence of equipment maintenance logs and testing. All portable electrical equipment was tested annually with the latest test carried out in May 2014. We saw evidence that equipment such as digital blood pressure machines, fridge thermometers, weighing scales and nebulisers had been checked and calibrated by a qualified professional in January 2014.

## Staffing and recruitment

The practice had a recruitment policy that set out the process it followed when recruiting both clinical and non-clinical staff. We saw records which confirmed that appropriate recruitment checks had been undertaken prior

to staff being appointed. These included references, qualifications and proof of registration with an appropriate professional body. All staff had received a Disclosure and Barring Service (DBS) check.

Staff told us about the arrangements for planning and monitoring the number of staff and their skills mix needed to meet patients' needs. Both clinical and non-clinical staff worked a rota system to ensure there was enough staff on duty at all times, providing cover for annual leave or sickness.

We were told that there had been problems in the past ensuring that there were sufficient staff on duty to meet patients' needs. As a consequence, two healthcare assistants had recently been appointed to carry out some of the work previously undertaken by the nurse. This included phlebotomy, sexual health screening and routine health checks. The practice manager showed us evidence to demonstrate that the current staffing level and skill mix was in line with the planned staffing requirements and staff stated that they were managing with the current levels. We were told of plans to employ more staff to expand the service, but this was dependent on a review of the space available in the premises.

## Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients and staff. This included health and safety risk assessments, medicines management and staffing protocols to ensure sufficient staff were present to cover patient demand. The practice had a health and safety policy and health and safety information was displayed for staff to see. A named staff member was the health and safety representative.

The practice worked with the Clinical Commissioning Group and the local practice network to identify risks within the practice and the patient population. This was reviewed at monthly meetings of the practice network, which members of the practice attended.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing that all staff had received basic life support training. Emergency equipment including oxygen was available. An external defibrillator (used to attempt to restart a person's heart in an

## Are services safe?

emergency) was available through the local ambulance service. All staff were aware of the location of the emergency equipment and we saw records to confirm that these were checked regularly.

Emergency medicines were available in a secure area and all staff were aware of the location. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that might be a risk to, or have an impact on the daily operation of the practice. Examples included a loss of power, adverse weather issues that might cause difficulty for staff to attend the practice and serious incidents in the locality.

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

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings which showed that new guidelines were discussed and shared. We found from discussions with GPs that staff completed thorough assessments of patients' needs which were reviewed when appropriate. The needs assessment was completed in line with NICE guidelines.

Clinical staff, including medical trainees, met together on a weekly basis to discuss patients and appropriate assessments in line with up to date published guidance.

The GPs told us that they each took the lead in areas such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. They were supported by the practice nurse who reviewed all chronic disease patients annually. Care plans were monitored by the practice on a monthly basis to ensure they remained up to date.

The practice referred patients to secondary care and other community care services appropriately. Data showed that the practice was performing in line with Clinical Commissioning Group (CCG) averages for such referrals.

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

### Management, monitoring and improving outcomes for people

The practice had achieved 97.4% in their Quality and Outcomes Framework (QOF) performance in the year ending April 2014. This was above both the Clinical Commissioning Group (CCG) and national average. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. QOF performance was a permanent agenda item discussed at practice meetings.

The practice showed us examples of clinical audits that had been undertaken over the last year in line with CCG

recommendations. These included an audit of transdermal fentanyl prescribing and prescribing of insulin for patients with type-two diabetes. This audit had been repeated. Actions for improvements had been identified as a result of the audits. For example, initiating monthly medication reviews and recording the collection of prescription scripts ensuring none went missing. The practice was able to demonstrate further audit cycles, in that audits had been repeated to assess if outcomes for patients had improved.

The practice participated in local benchmarking exercises run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The data showed that the practice was one of the higher performers compared to other services in the area. The data covered such issues as patients with diabetes who had a written care plan and attended an annual consultation in the last 15 months (89% compared to the local average of 82%), and the percentage of smoking patients that consented to intervention (96% for July 2014 compared to the local average of 84% for the same period).

The practice was also involved in monthly network meetings with other local practices to discuss and improve outcomes. Targets for performance improvement were discussed and agreed at the meetings.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with the mandatory courses such as basic life support, health and safety, safeguarding and information governance. However, we found no evidence of staff completing infection control training. All GPs were registered with the General Medical Council (GMC) and were up to date with their continuous professional development requirements. All had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had completed an induction programme when they started working for the practice.

# Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals which identified learning needs from which action plans were produced. Staff told us that they were encouraged to develop and contribute to their personal development plans. The practice provided opportunities for further training and promotion. For example, reception staff were encouraged to consider progressing to the role of healthcare assistant with appropriate training.

## Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood test results, X ray results, hospital letters and reports from the out of hours service was received by secure email and by post. Once received, the letters were actioned by the duty GP. All staff we spoke with understood the system for processing correspondence and their responsibilities.

The practice held monthly multidisciplinary meetings to discuss the needs of complex patients. For example, to discuss the needs of older people with their care coordinator, district nurses and social services, if appropriate. Meetings were also held with palliative care nurses (for end of life care), MacMillan Nurses, health visitors, midwives and mental health professionals. The decisions about care planning were documented in a shared care record. We were provided with copies of the multidisciplinary team meetings which provided evidence that patients' needs were being discussed and care plans maintained.

The practice was a member of a local network of providers. This network consisted of 12 practices who worked together to provide enhanced services and to provide monthly target to monitor and raise performance and outcomes for patients. For example setting an individual target for the number of health checks provided by each surgery.

## Information sharing

Patients were referred to other services on the same day by GPs. We found the practice had an efficient referral process in line with national guidance. Patients we spoke with were content with the referral process. They said they always received a prompt referral to their preferred care service.

The practice had systems in place to provide staff with the information they needed to carry out their responsibilities. An electronic patient record was used by all staff to coordinate and manage patient care. All staff were fully

trained on the system. The software enabled scanned paper communications, such as hospital discharge letters, to be saved to the patient record. The practice also shared notes with out of hours providers for those patients with complex health needs to enable continuity of care.

## Consent to care and treatment

We found that staff had an understanding of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and were aware of their duties in comply with the legislation. All the clinical staff we spoke to knew the key parts of the legislation and were able to describe how it was implemented in day to day practice. For example by ensuring that carers and patients' representatives were acting in the patient's best interest and involved in the consent procedure. For those patients with a mental health concern or learning difficulty, the patient, carer or representative were fully informed before written consent was sought. One of the GPs attended a consent training session and this was shared with all members of staff at a practice meeting.

GPs demonstrated an understanding of both Gillick competencies and Fraser guidelines (which are used to identify children under 16 years who have the legal capacity to consent to medical examination and treatment without parental permission or knowledge) and were able to give examples of when they had used them. The practice also had a protocol to ensure that correct consent was received from those patients with a learning disability.

## Health promotion and prevention

The practice had met with the Public Health team from the Local Authority and the Clinical Commissioning Group (CCG) to discuss the implications and share information about the needs of the practice population identified in the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about health and social care needs of the local area. This information was used to help focus health promotion activity.

It was a practice policy to offer all new patients registering a health check with the healthcare assistant or practice nurse. The GP was informed of all health concerns and a follow up appointment was provided if necessary.

The practice did not have a large population of older people and did not currently provide a service to any care or nursing homes. All patients over the age of 75 had a designated named GP and home visits were available for

# Are services effective?

## (for example, treatment is effective)

patients who were unable to attend the surgery. Follow up telephone consultations with the GP were offered within 48 hours of patients being discharged from hospital. This would be followed by a full consultation at the practice to review the patient's care plan. Flu vaccinations were offered to all patients over the age of 75 and the uptake for this was in line with the national average. The practice had adopted the summary care record for all patients on the older persons register, long term conditions registers or those patients that were vulnerable or who had a mental health concern. This enabled effective sharing of patient information between services. The practice offered cognition testing to all patients over the age of 60. This was also offered to patients with a learning disability and those involved in substance misuse, such as alcohol or drugs.

The practice held long term conditions registers of patients with included asthma, diabetes and chronic obstructive pulmonary disease (COPD). Each patient on the registers received a personalised care plan. The plan was routinely reviewed every quarter, more frequently should their conditions or circumstances change. We reviewed six care plans and found they had been updated and were relevant to the individual patient. Referrals were made through a central point of access provided by the Clinical Commissioning Group (CCG) which allowed care plans to be sent to any secondary care referral. Patient care was reviewed through annual health reviews, which included a physical health check and medicines review. All patients on these registers had a named GP appointed. Home visits were available for those who had difficulty attending the practice.

The nurse identified appropriate patients for a cervical smear test and invited them for screening. The practice's performance for cervical smear test uptake was 67%. This was lower than the Clinical Commissioning Group (CCG) average of 72.9% and the England average of 78.3%. The practice was aware of this lower than average uptake and was promoting the health benefits of this test to improve the uptake. The practice sent reminder letters to patients who had not responded or who had not attended screening appointments

Childhood (including baby) immunisations were offered by the practice. The practice performed above the CCG average for all immunisations. For example, there was a 96.9% uptake for the MMR vaccination compared the CCG average of 90%. The nurse also offered lifestyle advice, family planning, wound care, spirometry and chronic disease management clinics.

GPs prepared reports for child protection meetings and if appropriate, would to attend. The practice safeguarding lead met with health visitors every two months to discuss children and families on the practice at risk register. Vulnerable patients and children who might be at risk were flagged up on the computerised records system to alert staff.

The practice worked with community midwives and health visitors to provide antenatal and post natal care. We saw during the inspection a baby clinic conducted in which health visitors carried out childhood health checks.

The practice ran a clinic at the local university which offered student specific services. These included health checks and sexual health advice and screening. Sexual health screening was available at the practice for the wider patient population, along with the NHS health check and smoking cessation advice provided by the nurse.

The local CCG ran a service elsewhere to provide treatment for people with no fixed address, and who might not be registered with a doctor. However, the practice would see people as an emergency patient, to deal with their immediate needs, and then signpost them to the CCG-run service for further assistance.

The practice met with the community mental health team every two months and monthly with the community psychiatric team to discuss individual patients. The practice also had a named psychiatric consultant and specialist mental health nurse attached to the surgery. We saw minutes of meetings which confirmed that when patients were being considered to be discharged from hospital into the community appropriate support was provided by the practice. The practice also signposted patients to organisations such as MIND for further assistance.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National Patient Survey (NPS) and a Mori poll undertaken by the practice. The evidence from these sources showed patients were happy with the service they received and they were listened to by staff and treated with respect. Data from NPS showed that 73% of patients said the last GP they saw or spoke to was good at treating them with care and concern. This was above the Clinical Commissioning Group (CCG) average. The survey also showed that 76% said that the last GP they saw was good at giving them enough time which was also above the CCG average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 15 completed cards and the majority were positive about the service experience. Patients said they were listened to by the staff, they felt involved in planning of their treatment and that the environment was clean and safe. Three of the comment cards were less positive, with patients stating that it was difficult for them to get through on the telephone to make an appointment. This was an issue the practice was aware of and it was putting a new telephone system in place to improve the access.

We also spoke with ten patients on the day of inspection, who were happy with the service provided.

Staff and patients told us that all consultations were carried out in the privacy of the consulting room. Disposable curtains were provided in consulting rooms, so that patient dignity was maintained during examinations. We noted that the doors to the consulting rooms were closed during a consultation to respect patient confidentiality. The practice provided a chaperone for any patient who requested one. Information on the chaperone service was on display in the reception area.

We noted that patients speaking at the reception desks were not overheard by patients in the waiting area. We were informed that a consulting room was kept free in case a patient wished to talk to a member of staff in private before their consultation.

Staff told us that if they had any concerns or observed any discriminatory behaviour they would raise these with the practice manager, who would investigate the circumstances.

We found that the practice had a culture of ensuring that patients were treated equally. Therefore those patients with mental health concerns or otherwise vulnerable were able to access the service without fear of prejudice.

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

Patient survey information showed patients responded positively to questions about their involvement in the planning of their care. For example, national patient survey (NPS) results showed that 61% of patients said that the GP was good at involving them in their care, which was below the Clinical Commissioning Group (CCG) average, and 72% said that the GP was good at explaining test results and treatments, which was above the CCG average. The NPS showed that 100% of patients said that they had confidence in the nursing staff which was above the CCG average of 91%.

The results from the practice's own satisfaction survey showed that 54% of patients said they were sufficiently involved in making decisions about their care. However, patients we spoke with on the day had no concerns regarding involvement in their treatment. All patients said that they were involved in the decision making process and that all the options for treatment were explained to them. They also told us they felt listened to and supported by staff to make the right decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as their first language. Patients were asked by the receptionist if they required a translator. The service was advertised within the practice.

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

The practice led quality survey information we viewed showed that people were positive about the emotional support that was provided by the practice. People told us that when they needed such support the GPs would do whatever they could to provide an appropriate referral to another service or by giving them information of how they could access relevant support groups. In the event of bereavement, the practice would send a condolence card,



## Are services caring?

along with information of services that could be of assistance at that time. We viewed information within the reception area which signposted patients to external support groups.

The practice had a carer's policy and the practice computer system alerted GPs if a patient was also a carer. We were shown written information signposting carers to support groups.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to people's needs and that it 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 ensure that the service provided remained appropriate to the needs of the local population. The practice undertook an analysis in conjunction with the Clinical Commissioning Group (CCG) to identify the needs of the local area and plan services accordingly. For example, there was a high proportion of students which had resulted in tailored health promotion and the establishment of a student health service at the local university.

Longer appointments were available to patients who requested them. Those with long term conditions, mental health concerns and otherwise vulnerable patients were able to book appointments at quieter times of the day. Elderly and vulnerable patients were able to access an appointment with their named GP when required. Home visits were offered for those patients who were unable to attend the surgery. Telephone consultations were available for those patients who worked during surgery opening times.

A register was held which identified those older people who were high risk of admission to hospital or who were approaching end of life. We reviewed care plans that were kept up to date and shared with other healthcare providers. The practice provided a follow up consultation to patients that had been discharged from hospital if there was a need. All patients over the age of 75 received their own named GP.

A register of those patients whose circumstances made them vulnerable was maintained. Those patients with a learning disability were offered longer appointments to give time to discuss health concerns. All patients with a learning disability received an annual follow up and health check.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss patients' and their families' care and support needs.

The practice had set up a patient participation group (PPG). However, the practice had found it to be poorly supported and in need of further development. The practice was

currently advertising for more patients to become involved. The PPG met infrequently, with roughly five month intervals. Staff said the PPG was helpful, allowing patients and the practice to work together to move the practice forward. However, no minutes of PPG meetings were available and it was not clear what discussions had taken place.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example staff had been trained to help victims of domestic violence and the practice ran a substance misuse clinic including a specific clinic for young people and alcohol misuse within a local community.

The practice had access to local translation services and patients with communication needs were given longer appointments.

The premises and services had been adapted to meet the needs of people with disabilities. This included level access for wheelchair users and those with mobility scooters. The practice had appropriate toilet facilities, suitable for use by patients with disabilities. Staff had completed training in equality and diversity.

### Access to the service

Patients we spoke with said they could get an appointment easily and at a time that suited them. This was reflected in the Care Quality Commission (CQC) comments cards we received and the National Patient Survey (NPS) results in which the practice scored above the CCG average for the experience of making an appointment (71%) and the convenience of appointments (96%).

The practice was open for appointments between 8.45am and 6.30pm each week day, except Thursdays, when specialist clinics were run between 2pm and 5pm. Appointments were offered on the day or within 48 hours. Appointments could also be pre-booked up to one month ahead. Appointments could be made by patients attending in person, by telephone or online. Urgent appointments were available on the same day with the duty GP. Appointments were usually 10 minutes in length. However, longer appointments were available for those with long term conditions and learning difficulties. Specific appointments were available, for example, for health checks, which lasted 30 minutes. Telephone consultations



# Are services responsive to people's needs?

(for example, to feedback?)

and home visits were also available for those patients unable to attend the practice. Appointments were made available outside school hours for those that required them.

Information was available to patients in the practice leaflet and on the practice website. This information included the times of sessions and how to book an appointment. The website included a link to the online booking system.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out of hour's service. Information regarding the out of hour's service was provided within the practice, on the telephone answering service and on the practice website.

The practice was situated on two floors with consultation rooms on the ground floor and administrative offices on the first floor. The practice was accessible to patients with wheelchairs, mobility scooters and prams. The waiting area was small and the inspection team had some concern for access when a number of push chairs were present. However, the practice ensured that access to the consultation rooms was kept free at all times.

## Listening and learning from concerns and complaints

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

We found that the complaints procedure was advertised and information was available in the reception area for patients to take away with them. Patients we spoke with were aware of the procedure, but none had used it.

We looked at five out of the 20 complaints received over the last 12 months and found that they had been responded to appropriately, in line with the practice policy. Complaints were reviewed by the GPs and discussed in the relevant team meeting to enable learning from the complaint.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision and strategy to address the health needs of the local population by providing high quality health care. Staff we spoke with were able to talk about the practice's vision. Staff were actively encouraged to participate in the planning and reviewing of services provided by the practice. An on going staff workshop was held to discuss the practice, identify what was good and what needed improving in order to identify a clear strategy for the practice to move forward.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We viewed six policies including medicines management, safeguarding, and recruitment and infection control and found them to be relevant to the operation of the practice. We found all policies to be in date. Named staff members were assigned within the policies to be responsible for particular areas of governance, such as infection control, safeguarding and medicines management.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for the practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice was also a member of a local network of practices which worked together to provide enhanced services. At each network meeting benchmark targets were set against which the practices could monitor their performance. The practice was benchmarked against areas such as the percentage of patients with diabetes that had a care plan and the uptake of the first health check amongst the eligible population.

The practice had conducted a number of clinical audits. These included medicines prescribing, an asthma review and patient attendance at secondary care. The audits showed that improvements could be made through changes in practice. For example the practice undertook a base line survey of patients that attended the local urgent care centre to identify frequent attenders. It was found that patients attended for minor ailments such as coughs and colds which could have been treated at the practice. The practice contacted these patients by letter and invited

them for a consultation with the GP and also advised them to attend the practice first. The practice could demonstrate that full audit cycles had taken place where audits had been repeated to evidence improvements.

The practice had robust systems, processes and policies in place to manage and monitor risks to patients and staff. This included health and safety risk assessments, a medicines management policy and staffing protocols to ensure sufficient staff were present to cover patient demand. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identifiable named health and safety representative. We saw that risks were regularly discussed in both clinical and practice meetings.

### Leadership, openness and transparency

We were shown that the practice had a clear leadership structure, which named members of staff in lead roles. For example, there was a lead nurse for infection control and medicines management and there was GP lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They told us that they felt valued and supported and knew who to go to with any concerns.

We saw from minutes that full team meetings were held monthly, with clinical meetings and reception staff meetings held weekly. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues in meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy and staff induction policy which were in place to support staff. The policies were up to date and suitable for purpose. Staff knew where to find these policies if needed.

Clinical staff were subject to external peer review by other practices within the local network. This included providing case studies at monthly network meetings for other practices to discuss the outcomes that had been given by the practice.

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

The practice had gathered feedback from patients through patient surveys, a comments box and complaints received. The practice had developed an action plan as a result of the latest patient questionnaire and made improvements

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to the service. For example, patients raised concerns about getting through to the surgery by telephone to book an appointment. The surgery responded by changing the telephone service provider and by promoting the practice's online services to free up time on the telephone.

The practice had a patient participation group (PPG). However the group met infrequently. We viewed the minutes for the latest PPG meeting in which the re introduction of the patient comments box and a premises update were discussed. The practice had advertised for more patients to join the PPG including patients from the student population. The practice had considered developing a virtual PPG to reach this population group.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at staff records and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training.

The practice had completed reviews of significant events and other incidents. It shared lessons it had learned with staff within meetings to ensure the practice improved outcomes for patients. For example, an incident of meningitis occurred within the student population of the practice. Patients were contacted and made aware. Measures were put in place to prevent recurrence. The incident was discussed during a staff meeting to ensure learning was shared.