Lister Lane 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lister Lane on 21 April 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all the population groups. It required improvement for providing safe services.

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.
- 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.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- Risks to patients were not always assessed and well managed. The practice did not have an infection control audit or fire assessment completed in the last 12 months.
- Not all staff were aware who took the lead for infection control.

The areas where the provider must make improvements are:

- Ensure an infection control audit is completed and action plan implemented in accordance with the findings.
- Ensure a fire assessment of the premises is completed and action plan implemented in accordance with the findings.
- Ensure a risk assessment for legionella testing is completed and action plan implemented in accordance with the findings.

In addition the provider should:

- Review the storage of medicines to ensure they are stored safely and securely and a stock list is kept.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough enough and lessons learned were communicated to support improvement. However, some risks to patients who used services were not assessed. The systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. An infection control audit had not been performed in the last 12 months. A fire risk assessment of the premises had not been completed in the last 12 months.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received other training appropriate to their roles. Further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice as comparable to those in the local area. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as requires improvement for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. Staff could not tell us who took the lead for infection control. Staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity and held annual governance meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for people with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for working age people (including those recently retired and students).The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these

were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia). Ninety three percent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Staff at the practice showed us details of various support groups and voluntary organisations which they would share with patients'. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had attended information sessions on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We also spoke with seven patients on the day of our inspection. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They also told us the practice was always clean and tidy.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015. The evidence showed patients were mainly satisfied with how they were treated and this was with compassion, dignity and respect. The practice was below the CCG average for its satisfaction scores on consultations with nurses with 69% of practice respondents saying the nurse was good at listening to them and 63% saying the nurse gave them enough time. The GP scores were slightly lower than the CCG average with 79% of practice respondents saying the GP was good at listening to them and 80% saying the GP gave them enough time.

Reception scores were comparable to the CCG average as 89% said they found the receptionists at the practice helpful.

Areas for improvement

Action the service MUST take to improve

- Ensure an infection control audit is completed and action plan implemented in accordance with the findings.
- Ensure a fire assessment of the premises is completed and action plan implemented in accordance with the findings.
- Ensure a risk assessment for legionella testing is completed and action plan implemented in accordance with the findings.

Action the service SHOULD take to improve

- Review the storage of medicines to ensure they are stored safely and securely and a stock list is kept.

Lister Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor, practice manager specialist advisor and a practice nurse specialist advisor.

Background to Lister Lane Surgery

Lister Lane Surgery is located in the centre of Halifax. The practice is part of Calderdale Clinical Commissioning Group (CCG) and responsible for providing primary medical services for approximately 7,434 patients under the general medical services (GMS) contract with NHS England. The practice catchment area, which includes the city centre, is classed as within the group of the most deprived areas in England.

Lister Lane Surgery has branch surgeries at Nursery Lane Surgery and Boothtown Surgery. They have one single patient list, so patients can be seen at any location depending on which is more convenient for them. The practice has three GP partners (two male and one female), one female salaried GP and one female locum GP. Two GPs rotate between the three locations. They are supported by two practice nurses, one of which was an independent nurse prescriber and three health care assistants. Each surgery has its own practice manager and reception staff. We visited Lister Lane Surgery and Nursery Lane Surgery on the day of our inspection.

Lister Lane and Nursery Lane is open from 8am to 6.30pm Monday to Friday. Lister Lane is open Monday evenings until 8pm. Boothtown Surgery is open from 6.40am on Thursday mornings. GPs offered telephone triage to those patients' requesting an urgent appointment.

Lister Lane Surgery is registered to provide; diagnostic and screening procedures and the treatment of disease, disorder or injury from 30 Lister Lane Halifax HX1 5AX. We noted surgical procedures were performed at Lister Lane which is not currently part of their registration. The practice manager told us the application to add surgical procedures to their registration was in progress.

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 registered 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.

Please note 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 visiting, we reviewed information we hold about the practice and asked Calderdale CCG and NHS England to share what they knew. We carried out an announced visit

Detailed findings

on 21 April 2015. During our visits we spoke with two GPs, two practice managers, two nursing staff, three healthcare assistants and four members of the administrative team. We also spoke with seven patients who used the service and reviewed 24 comment cards where patients shared their views and experiences of the service.

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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, we were told a patient's care was reviewed following a clinical incident. Staff told us how they revisited the care pathway to ensure it was followed.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

Significant events were a standing item on the monthly joint practice meeting agenda with Nursery Lane and Boothtown surgeries. A dedicated meeting with all three practices was held annually to review actions from past significant events and complaints.

Staff completed incident forms on the electronic risk management system which were then assigned to a manager to investigate. The practice manager showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and the learning had been shared with staff at the practice meeting. Where patients had been affected by something which had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the lead GP to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the quarterly practice meeting to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding to level three and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations and the local authority. Staff told us health visitors were contacted when needed.

GPs were appropriately using the required codes on their electronic patient record system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies, such as the police and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice website. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The

practice manager told us all reception staff undertaking chaperone duties had a recent Disclosure and Barring Service (DBS) check submitted and they were waiting for them to be returned. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found some medicines were stored in unlocked drawers in the nurses' room which was not locked. We also observed a medicine in a letter tray in the administration area of reception. This was highlighted to the practice manager who told us the medicine was in the tray as the room where it was stored was in use. We noted the practice did not have a list of stock medicines.

There was a policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers were kept securely but not tracked through the practice. Prescription pads were kept secure and tracked.

We saw records of meetings which noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We were shown a review of all antibiotic prescribed over a week period. The audit identified all antibiotics were appropriately prescribed and the outcome documented the review would be repeated in three months' time.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

Cleanliness and infection control

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the infection control policy. Reception staff told us how they would deal with specimens from patients which followed the practice procedure. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

When we spoke to staff they could not tell us who took the lead for infection control. Nursing staff told us they had undertaken further training in infection control. All staff received induction training about infection control specific to their role and received annual updates. We asked to see an infection control audit completed within the last 12 months. We were told one had not been carried out.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We noted not all of the hand soap dispensers were wall mounted.

We saw records a test for legionella, (a bacterium which can contaminate water systems in buildings), was completed in 2009. Regular checks were not completed and they had not undertaken a risk assessment for legionella to determine the risk in the premises.

Equipment

Requires improvement

Are services safe?

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

Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave at this practice and Nursery Lane. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We asked to see a fire risk assessment. We were told one had not been completed in the past 12 months. Staff told us the fire alarm was not tested regularly and fire evacuation drills were not performed. Records showed staff were up to date with fire training.

The appointments systems in place allowed a responsive approach to risk management. For example, when there were no appointments available for people who requested an urgent appointment on the same day, the GP would be informed and phone the patient back[HA1] .

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and oxygen. All members of staff we spoke with knew the location of the equipment and records confirmed it was checked regularly. We noted two of the syringes in the emergency medicines box were out of date.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included adrenaline (which can be used to treat anaphylaxis) and hydrocortisone (for treating asthma or recurrent anaphylaxis). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the emergency medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the utility companies if power was lost.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw guidance from local commissioners was readily accessible in all the clinical and consulting rooms. We were also told how GPs used the clinical pathways in the map of medicine computerised support system. It provided comprehensive, evidence-based local guidance and clinical decision support at the point of care. We were shown how it was used to support a patient on a drug withdrawal programme.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We were told this was discussed at clinical meetings where implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

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

The GPs told us they had a lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which 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. GPs told us this supported all staff to review and discuss new best practice guidelines, for example for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. We saw after patients were discharged from hospital they were followed up within three days to ensure all their needs were continuing to be met. We were told the hospital pharmacist would send a message to the GP via the patient record system of any changes to the patient's prescribed medicines. The GP would then review the patient record and amend the prescribing record accordingly.

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

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles. The practice showed us four clinical audits which had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, an audit of a medicine used to treat anxiety was carried out. The aim of the audit was to ensure all patients who were prescribed this medicine met the treatment criteria. The first audit demonstrated some patients' did not meet the treatment criteria. The information was shared with GPs and patients were called for a medication review. A second audit was completed one year later which demonstrated all patients prescribed the medicine met the treatment criteria.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a

Good

Are services effective?

(for example, treatment is effective)

result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 98.8% of the total QOF target in 2014, which was above the national average of 94%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related and hypertension QOF indicators were better than the national average.

The dementia diagnosis rate was above the national average and 88% of patients' with dementia had an annual review, which was higher than the CCG average of 83%.

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

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long term conditions, such as diabetes, and the latest prescribing guidance was being used. The IT system flagged up relevant medicine alerts when the GP was prescribing medicines. We saw evidence after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had a palliative care register and had quarterly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes were comparable to other services in the area. For example, prescribing trends and patient satisfaction. We were told how the CCG had split the GP practices in the area into clusters. We were told how the practice's performance was monitored in this cluster and the wider group to highlight areas of good practice and identify peer support for those who needed it.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals identifying learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses. For example, a member of reception staff told us how they were being supported to complete a healthcare assistant course.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology and child immunisations. Those with extended roles who saw patients with long term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results and letters, including discharge summaries, from the local hospital, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries which were not followed up.

Emergency hospital admission rates for the practice were 24% compared to the CCG average of 26%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the policy for actioning hospital communications was working well in this respect. We were told a yearly audit of follow-ups had not yet been completed.

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

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

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported this system was easy to use.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, those patients' on the palliative care register making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. We noted not all staff had completed formal training on the Mental Capacity Act.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care

Good

Are services effective?

(for example, treatment is effective)

plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. The care plan included a section stating the patient's preferences for treatment and decisions.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

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

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

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients within two weeks if they had identified risk factors for disease at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 91% of patients over the age of 16 and actively offered smoking cessation clinics to 91% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 74%, which was below the local average of 80% and national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was comparable to the local area for the majority of immunisations where the data was available.

Practice staff showed us the resources available to patients experiencing poor mental health. This included voluntary sector agencies to promote independent living and patients could be referred to primary care based talking therapies. Annual health reviews were offered to patients with severe mental health issues and the uptake was 93% which was above the average of 86% for the local area. Patients were offered flexible appointment times, avoiding booking appointments at busy times for people who may find this stressful.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey in January 2015.

The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national GP patient survey showed the practice was slightly below the local average for its satisfaction scores on consultations with doctors and nurses. For example:

- 79% said the GP was good at listening to them compared to the CCG average of 88%
- 80% said the GP gave them enough time compared to the CCG average of 86%
- 86% said they had confidence and trust in the last GP they saw compared to the CCG average of 93%
- 69% said the nurse was good at listening to them compared to the CCG average of 79%
- 63% said the nurse gave them enough time compared to the CCG average of 81%
- 86% said they had confidence and trust in the last nurse they saw compared to the CCG average of 93%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. We noted curtains were not provided in consulting rooms and treatment rooms. We did observe consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located in reception and was shielded by a glass partition which helped keep patient information private. Additionally, 89% of respondents in the national GP patient survey said they found the receptionists at the practice helpful which was comparable to the CCG average.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients rated GPs and nurses lower than the CCG average regarding their involvement in planning and making decisions about their care and treatment. For example:

- 77% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82%
- 64% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 74%
- 68% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 79%
- 62% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 67%

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

Staff told us translation services were available for patients who did not have English as a first language. We saw

Good

Are services caring?

notices in the reception areas informing patents this service was available. Several practice staff spoke different languages. For example, a receptionist and the GP spoke Urdu.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. The scores were slightly below the CCG average. For example:

- 79% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88%.
- 71% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 78%

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

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

Staff told us if families had experienced a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice offered a GP triage service for those patients who requested an urgent GP appointment. The GP would telephone the patient back, assess their symptoms and offer an appointment in the practice later that day if needed. Patients told us they liked this system as it was flexible and they did not always have to come to the surgery.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, we were shown prescribing information for all the practices in the area. The GP told us how the practice monitored this to promote prescribing compliance.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the practice had recruited extra administration staff to answer the telephone in response to patients reporting difficulty getting through to the practice by telephone.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. We were told patients who were considered vulnerable could come into the practice and an appointment would be offered to them at the end of clinic. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

Staff at the practice spoke different languages including Urdu and Punjabi. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets. Baby changing facilities were available on request. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There were male and female GPs in the practice, giving patients a choice. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and equality and diversity was regularly discussed at staff appraisals and team events.

The practice held a register of people who may be living in vulnerable circumstances and had a system for flagging vulnerability in individual records.

Access to the service

Patients could choose to be seen at Lister Lane, Nursery Lane or Boothtown Surgery. Lister Lane and Nursery Lane was open from 8am to 6.30pm Monday to Friday. Lister Lane opening on Monday evenings until 8pm. Boothtown Surgery was open from 6.40am on Thursday mornings. GPs offered telephone triage to those patients' requesting an urgent appointment.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

with learning disabilities and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes when requested to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice similar to other practices in the area. For example:

- 71% were satisfied with the practice's opening hours compared to the CCG average of 74%.
- 74% described their experience of making an appointment as good compared to the CCG average of 73%.
- 45% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 56%.
- 76% said they could get through easily to the surgery by phone compared to the CCG average of 70%.

Patients we spoke with were satisfied with the appointments system but reported difficulty getting through to the practice by telephone, especially first thing in the morning. Once their call was answered they confirmed they could see a doctor on the same day if they felt their need was urgent, although this might not be their GP of choice. . They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, we were told a patient rang the practice requesting an urgent appointment. The GP rang them back and they were seen in the practice two hours later.

Appointments were available outside of school hours for children and young people and the premises were suitable for children and young people. Staff told us they worked closely with the local sexual health clinic. Patients reported the online appointment booking system was available and easy to use.

Staff told us they avoided booking appointments at busy times for people who may find this stressful.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We noted and fed back to the practice manager response letters should include details of the parliamentary and health service ombudsman for the complainant to pursue further if they felt necessary.

We saw information was available to help patients understand the complaints system. Leaflets were available and a poster displayed in the practice to explain the process. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months. They were satisfactorily handled, dealt with in a timely way and there was openness and transparency when dealing with the complaint.

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

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a statement of purpose, staff spoke enthusiastically about working thereand they told us they felt valued and supported. .Staff told us their role was to provide the best care to patients. We asked if the practice had developed an overall vision or practice values staff had taken time out to contribute to and staff told us this happened informally at the practice meetings where all staff contributed.

We were told the practice had a business improvement plan which included improvements to the building.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in files kept within the practice. We looked at 10 of these policies and procedures and all staff had completed a cover sheet to confirm they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually. We noted the recruitment policy referred to the Criminal Record Bureau. We fed back to the practice manager this had been replaced by the Disclosure and Barring Service. All other policies we looked at were up to date.

The practice had a leadership structure across the three locations. We spoke with five members of staff at Lister Lane and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. The full time GP was the lead for safeguarding and staff could tell us this. Staff were unable to tell us who took the lead for infection control at each location.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above local and national standards. The practice achieved 98.8% of the available QOF points for the year 2013-14 compared to the CCG average of 95.6% and the national average of 94%. We saw QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

We were not shown an on going programme of clinical audits; although we were shown the individual evidence they were taking place.

The practice had arrangements for identifying, recording and managing risks which were captured in the electronic risk management system. Whilst we found evidence some aspects were good, we identified a number of areas where improvements were needed. For example, the practice had not made sure there were proper arrangements in place for assessing the risk of and controlling and preventing the spread of infections and fire prevention. The individual risks were regularly discussed at team meetings and incident forms updated in a timely way.

The practice held monthly practice meetings where governance issues were discussed. We looked at minutes from the last three meetings and found performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes, team meetings were held monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies. For example, disciplinary procedures and the induction policy which were in place to support staff. We were shown the staff handbook was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, NHS Friends and Family test and complaints received. The practice had an active patient participation group (PPG) which had steadily decreased in size. We saw evidence in the practice and on the website they were actively trying to recruit more virtual members.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw regular appraisals took place which included a personal development plan. We were told the practice was very supportive of training and they had regular staff training days where guest speakers and trainers attended. In addition to this, clinical staff received five study days a year to maintain their professional development.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to help ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found the registered person had not protected people against the risk of inappropriate or unsafe care and treatment, by means of maintaining the premises and equipment. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because: A fire risk assessment had not been completed in the last 12 months. An infection control audit had not been completed in the last 12 months. Fire alarm tests and fire drills were not performed. A risk assessment for legionella had not been completed. The premises were last tested in 2009. Regulation 15 1 (e) 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.