Peter Street Surgery

Quality Report

Peter Street
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Peter Street Surgery on 17 June 2015. Overall the practice is rated as good.

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 older people, for 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 and people experiencing poor mental health (including people with dementia).

It required improvement for providing safe services.

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

- Although staff raised concerns and reported incidents and near misses. We found that some significant events were not being reported because not all staff either knew about the policy for reporting events or fully understood it. Events that were recorded were monitored, appropriately reviewed and addressed.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example working alongside a local supplier to provide audiology services and providing non- obstetric ultrasound, physiotherapy and family planning services for their own patients and those from other practices.
- 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 training 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.

Summary of findings

- Patients said they found it easy to make an appointment with a GP and that 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.
- 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.

Importantly the provider must:

- Ensure a systematic approach to reporting, recording and monitoring significant events, incidents and accidents.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.

Additionally the provider should

- Ensure that curtains and the waiting room carpet arer cleaned in accordance with the cleaning schedules.
- Ensure that all staff understand the chaperone policy and that all staff who act as chaperones have the risks of their acting as chaperones assessed.

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 must make improvements. Although staff raised concerns and reported incidents and near misses. We found that some significant events were not being reported because not all staff either knew about the policy for reporting events or fully understood it. Events that were recorded were monitored, appropriately reviewed and addressed. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality with the exception of some regular health checks. The practice was aware of this and had taken action to improve. Staff referred to guidance from the National Institute for Health and Care Excellence 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 training appropriate to their roles and any further training needs had been identified and appropriate training 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 that patients rated the practice higher than others for several aspects of care. 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 that 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 GP, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet

Summary of findings

their needs. Information about how to complain was available and easy to understand and evidence showed that 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 good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. 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 that outcomes for patients were good for conditions commonly found in older people with the exception of some regular health checks. The practice was aware of this and had taken action to improve. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. 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 most had had a structured annual review to check that their health and medication needs were being met. There were some exceptions to the regular health checks for long term conditions. The practice was aware of this and had taken action to improve. 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 excellent, in every area outperforming the locally achieved results, often significantly so. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice recognised that there was shortage of family planning support locally. One of the partners had recently started a weekly family planning clinic, this was also open to patients from other local practices. There was a designated member of staff to ensure that six to eight week baby checks were arranged, conducted and monitored correctly.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of 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 reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Approximately 87% 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 was working with the local clinical commissioning group to develop improved services for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Most staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with four patients. We did not receive any completed comment cards. The patients we spoke with were pleased with the quality of the care they had received. They said that the staff were very kind and considerate.

There is a survey of GP practices carried on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 318 survey forms were sent out to patients registered at this practice and 99 were returned. The number returned was below what would normally be expected.

The main positive results from this were that:

- 96% said that the last nurse they saw or spoke to was good at giving them enough time, the local and national results were 94% and 92%
- 99% had confidence and trust in the last nurse they saw or spoke to, the local and national results were both 97%
- 94% say the last nurse they saw or spoke to was good at treating them with care and concern, the local and national results were 92% and 90% and
- 37% usually wait 15 minutes or less after their appointment time to be seen, the local and national results were 68% and 65%

The main negative results were that:

- 44% find it easy to get through to this surgery by phone, the local and national results were both 74%
- 21% with a preferred GP usually get to see or speak to that GP, the local and national results were 60% and 62%
- 45% describe their experience of making an appointment as good, the local and national results were 75% and 74% and
- 42% would recommend this surgery to someone new to the area, the local and national results were 76% and 78%.

Areas for improvement

Action the service MUST take to improve

- Ensure a systematic approach to reporting, recording and monitoring significant events, incidents and accidents.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.

Action the service SHOULD take to improve

- Ensure that privacy curtains and the waiting room carpet are cleaned in accordance with the cleaning schedules.
- Ensure that all staff understand the chaperone policy and that all staff who act as chaperones have the risks of their acting as chaperones assessed.

Peter Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Peter Street Surgery

Primary medical services are provided Monday to Friday between the hours of 8.30am and 6.pm. There are evening surgeries from 6.30pm to 7.30pm twice a week. The switchboard is closed during lunchtime from 1pm to 2pm. There are six appointments set aside for patients with "urgent on the day" problems. The practice is situated in an urban area of Dover. It provides a service to approximately 7,300 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing team. The practice age demographics are similar to the national averages although it has approximately one third more patients registered over the age of 75 and over the age of 85 than the national average. Deprivation, including income deprivation, is marginally higher than that nationally. The percentage of the population declaring that they have a long tern health condition is about one third higher than nationally as is unemployment.

The practice has three partners, two male and one female. There are two female practice nurses. Regular locum GPs work in the practice on regular days each week and cover when the GP is on holiday. There are a number of administration staff, and a practice manager.

The practice does not provide out of hours services to its patients and there are arrangements with another provider Integrated Care 24 (IC24) to deliver services to patients when the practice is closed. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from:

Peter Street Surgery

Peter Street

Dover

Kent

CT16 1EF.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 17 June 2015, During our visit we spoke with a range of staff including two GP partners, nursing staff, receptionists and administrators. We spoke with patients who used 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risk and improve quality regarding patient safety. For example they considered accidents, national patient safety alerts as well as comments and complaints received. Staff we spoke with felt confident that they could raise any safety issues with the GPs and nursing staff. The staff were aware of their responsibilities to raise concerns. There was a policy to guide staff on what was a significant event.

Learning and improvement from safety incidents

There had been three reported events. Two concerned prescription errors and one the reporting of patient test results. There was learning from these events, for example the practice had changed the times when GPs were still on the premises as a result of one event. There were examples where individuals had also learned from the events. However we found some significant events which, though they had been resolved without detriment to the patients, had not been reported as significant events. This appeared to be because not all staff either knew about the policy or fully understood it. We discussed this with the practice and they were able to add further instances where there had been events which ought to have been recorded as significant events. The practice accepted that there were improvements needed in the reporting of events.

There was a process for dealing with safety alerts. These were received by the practice manager and passed to the GPs and nurses when the alerts were relevant. We looked at one recent alert concerning a medicine used for the relief of the symptoms of nausea. The alert advised that risk minimisation measures were necessary including restricted indications, use of lower doses, shorter treatment duration, addition of contraindications, warning and precautions. We checked anonymised patient records and all the patients to whom the alert applied had been reviewed and appropriate changes made to their medication.

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 that staff had received relevant role specific training on safeguarding. For those who had not there was safeguarding training arranged. 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 child safeguarding to the appropriate level (level three). All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. We talked through examples of safeguarding incidents and were satisfied that the staff had responded correctly. These incidents spanned both child and adult safeguarding matters.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans.

There was a chaperone policy. There were posters about chaperoning displayed on the waiting room noticeboard but they were not on display in the consulting rooms. There were sufficient staff trained to act as chaperones, there had been recent training for chaperones and further training was planned.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures and the temperatures were checked. There was a stock control process to ensure that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The patterns of anti-biotic, hypnotics, sedatives and anti-psychotic prescribing were within the range that would be expected for such a practice. The nurses administered vaccines using patient group directions that had been produced in line with legal requirements and

national guidance. There was evidence that nurses had received appropriate training to administer vaccines. The practice met regularly with the local prescribing advisor to review prescribing practice.

Cleanliness and infection control

The premises were clean and tidy. The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were well stocked with personal protective equipment (PPE) including a range of disposable gloves, aprons and coverings. We saw that antibacterial gel was available in the reception area for patients and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice.

The practice had a lead for infection control who was qualified to provide advice on the practice infection control and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. 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, PPE was available to staff and staff were able to describe how they would use the equipment to comply with the practice's infection control policy such as the use of disposable couch coverings and the treatment of hazardous waste.

During our inspection we saw that the practice used washable cloth privacy curtains in the consultation rooms. There was no record of when they had last been washed. The practice did not have spare curtains to use when the existing curtains were being washed. The carpet in the patient waiting room was in need of cleaning. We discussed these issues with the practice and they undertook to address them.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and there was a schedule for ensuring that was done when required. The practice had a contract with a reputable medical devices servicing company to do this work.

Staffing and recruitment

Personnel records confirmed that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and criminal record checks through the Disclosure and Barring Service (DBS). Nurses and Healthcare assistants were normally available to act as chaperones and had had criminal records checks. There was no evidence of other staff acting as chaperones however staff we spoke with were unclear whether they could act as chaperones or what their response would be if asked. There were records to show that the professional registration checks for staff with the Nursing Midwifery Council or the General Medical Council had been completed and this included locums deployed at the practice.

We saw there was a rota system in place for all the different staffing groups to ensure that there were enough staff on duty. The rota system ensured that staff, including GPs, nurses and administrative staff covered each other's annual leave.

Monitoring safety and responding to risk

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety. The practice had identified the need for fire wardens, individuals had been identified and training for them had been booked. There was regular checking and maintenance of the building, for example alarms, heating and the lift.

There was a system governing security of the practice. Visitors' identity was checked and they were required to sign in and out using the dedicated book in reception. The staff reception area in the waiting room was always occupied and the door shut to prevent unauthorised access.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support (BLS). Emergency equipment was available including access to medical oxygen and to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of this equipment. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We checked the emergency medicines, they were in date and reviewed regularly.

Requires improvement

Are services safe?

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. There were local contingency plans for the outbreak of disease for example, Ebola.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment followed national best practice and guidelines. For example, the emergency medicines and equipment held by the practice were consistent with the guidelines issued by the Resuscitation Council (UK). The GPs and nurses used the guidelines from the National Institute for Health and Care Excellence (NICE) and local guidelines to deliver treatment in line with current best practice. There was a folder of NICE and local guidance which some staff used during consultations. Staff also used the practice's patient records system to access NICE guidance. Staff used local referral pathways that had been produced by the clinical commissioning group (CCG). The practice had purchased a proprietary software application, linked to the patient record, which provided local information, patient safety messages, medicines recommendations and advice at the point of prescribing. Examples of the use of NICE guidance included the use of ambulatory blood pressure machines, used by patients in their own home, to help provide a more reliable diagnosis of heart problems.

The GPs led in specialist clinical areas and, for example, individual GPs had interests in chronic obstructive pulmonary disease (COPD), diabetes, minor surgery and family planning. This allowed the practice to focus on specific conditions. There was a range of nurse clinics available to patients to support this approach. Clinics were available for, amongst others conditions, diabetes, mental health, asthma and heart disease. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice. Interviews with staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, managing child protection alerts and medicines management.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). (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 used the information collected for the QOF and reviewed performance against national screening programmes.

The QOF results indicated that the practice often achieved highly in terms of diagnosing patients with illness such as chronic kidney disease, epilepsy, obesity and rheumatoid arthritis. In this regard the practice was amongst the best in the area. Also evidence showed that this performance had been sustained over at least the last three years. For the 22 common conditions measured by QOF, the practice was above the national average in its diagnosis for 11, most of the remainder were only marginally below the national averages.

However the QOF results also showed very mixed results for the routine management of some diseases. This applies to the last publically available QOF results which are for the year ending March 2014. In some areas related to the routine management of disease the practice had experienced a severe drop in performance. This drop in performance was most noticeable in indicators which required the practice to administer a test or check of the patient within the last 12 (or sometimes nine) months.

For patients with hypertension, those who had had an annual review, with accompanying lifestyle advice, had fallen from 98% to 70% between 2013 and 2014. This placed the practice in the bottom 15% of practices in the country. For patients with diabetes, those receiving a foot examination, usually part of an annual assessment, the figure had fallen from 87% to 80% between 2013 and 2014. Similar performance was seen across the annual reviews recommended for the management of hypothyroidism 92% down to 85% and dementia 82% down to 76%. All of these results were in the bottom 20% of practices nationally

However for asthma the percentage of patients who had had an asthma review in the preceding 12 months was up from 68% to 76%, this latter figure placing the practice just above the local and national average. For patients with atrial fibrillation in whom stroke risk had been assessed in the last 12 months the figure was marginally up from 97% to 99%.

Good

Are services effective?

(for example, treatment is effective)

However the general trend had been down and appeared to indicate that patients were not having the checks at the standard intervals that the guidance for the best management of their disease indicated. The practice was aware of the fall in the performance against QOF over the last few years. The new partnership, which had taken over in October 2013, had made this a priority issue and we saw some results for the year ending March 2015 that showed marked improvements. They had achieved this by bringing in Saturday morning clinics and extra staff to provide these services for patients who had missed out on them.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. GPs and nurses undertook necessary training, for example the practice nurse was just completing the training necessary to initiate insulin for insulin dependent patients. We were told that some of the GPs had completed their revalidation and other GPs knew when there revalidation was due. All GPs and nurses were appraised annually.

The practice had a planned approach to training for staff. There was a record which showed staff and the training they had received. The records showed that essential training such as information governance and safeguarding had been completed by all staff. There was refresher training planned for basic life support for all staff in September 2015. Nurses had received training in the management of the long term conditions they cared for in their clinics.

A new practice manager had assumed responsibility when the new partnership began. There had been a large change of staff particularly administrative staff. Many of the staff and completed their annual appraisal and others had dates allocated for the appraisal. Staff said that the appraisal process was a useful one. It allowed staff to give and receive feedback on their performance and to highlight training and personal development issues. Some staff told us of training that had been discussed with managers, agreed and planned although it had not yet been delivered.

Working with colleagues and other services

The practice worked with other professionals such as, district nurses, social services, GPs and other specialists.

The practice made referrals by letter and fax and electronically. GPs used dictation equipment, referrals were sent to secretarial staff for completion. The system that was used for the dictation also tracked patient's referrals.

The practice had established links with other health providers, for example working alongside a local supplier to provide audiology services and providing non- obstetric ultrasound services for their own patients and those from other practices. The practice recognised that there was shortage of family planning support locally. One of the partners had recently started a weekly family planning clinic, this was also open to patients from other local practices.

The practice received test results and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There were processes to manage this correspondence and staff understood their responsibilities in relation to these. There was a rota of GPs tasked to check results so that the results were addressed promptly. Results were received at a generic "in-box" and there was a system to check that they had been actioned.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. The outcomes of the discussions were entered on the individual patient's notes. GPs and nurses also contacted the relevant professionals such as district nurses or social workers when there was a need.

The practice was commissioned for the unplanned admissions enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). It had identified the most vulnerable patients, they had been contacted and informed who was their care co-ordinator and named GP. There was a process to follow up patients discharged from hospital.

Information sharing

All information about patients received from outside of the practice was captured electronically in the patients' records. For example, letters received were scanned and saved into the patients' records by the practice. The practice had systems to provide staff with the patient information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

Good

Are services effective?

(for example, treatment is effective)

care. Staff were trained in the use of the system. Staff we spoke with liked the system, saying it was easy to use. There was software that enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We checked the system for receiving this information and found that correspondence was dealt with efficiently.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and provided guidance for staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent was recorded.

There was a separate consent in use for invasive procedures associated with the minor surgery carried out at the practice. This included the information about the procedure so that patients could make an informed decision to consent, or not.

Most staff had undertaken training in the Mental Capacity Act 2005. Staff who had not had formal training were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff. Mental capacity assessments were carried out by the GPs and recorded on individual patient records. The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support.

Health promotion and prevention

All new patients were offered a health check. They were given a questionnaire and an appointment with the nursing staff which included a new patient check. Those on repeat medications were referred to the GP so the required medication could be prescribed. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were told of several instances where these checks had led to the early diagnosis of long term conditions.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. They were all offered an annual physical health check and had taken this up. All had a named GP and had been informed who that was.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations was excellent, in every area outperforming the locally achieved results, often significantly so. The results for influenza vaccinations for patients over 65 years and for patients under 65 whose condition meant that they were at in increased risk if they caught influenza was in line with the local average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available from the national patient survey. There were 318 survey forms distributed for Peter Street Surgery and 99 forms were returned. This is a response rate of 31%. The survey showed that most patients felt they were treated with dignity and respect. Patients said that the GPs and nurse listened to them, explained tests as well as results and treated them with care and concern. The results for the survey were all slightly below the average for the clinical commissioning group (CCG). However the rate of return of the surveys was lower than elsewhere so the sample was small, making the comparisons less reliable than it would have been with a larger sample.

The patient survey information showed patients responded fairly positively to questions about their being treated with care and concern. For example, the data showed 76 % of respondents said the nurse treated them with care and concern and 72 % said the same of GPs. The national figures were 78% and 83 % respectively. The data showed 74 % said the nurse was good at listening to them and 76 % said the same of GPs. The national figures were 79% and 87 % respectively.

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. Although the layout of the reception area made it difficult to keep conversations confidential, staff were aware of this and took time and trouble to maintain confidentiality. There was a private area where patients could talk with staff if they wished. There was a lowered section of the reception desk so that staff could talk with patients who were wheelchair bound at their own level. There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. All the consulting rooms had substantial doors and it was not possible for conversations to be overheard. We saw that staff always knocked and waited for a reply before entering any of the rooms. The rooms were, if necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was necessary.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed concerning involvement in decisions about care reflected the position above and same caution about the size of the sample applies. Patients responded quite positively to questions about their involvement in planning and making decisions concerning their care and treatment. For example, data from the survey showed 60% of practice respondents said the nurse involved them in care decisions and 70% said the same of GPs. The national figures were 66% and 75% respectively. The data showed 74% of practice respondents said the nurse was good at listening to them and 76% said the same of GPs. The national figures were 77% and 82%.

Patients said that the GPs and nurses discussed their health with them and they felt involved in decision making about the care and treatment they chose to receive. For example, we saw that 41 out of 47 mental health patients had a care plan which had been discussed and agreed with them, and their relatives or carers where appropriate, during the last twelve months. Patients said staff explained the care and treatment that was being provided and what options were available. Patients also received appropriate information and support regarding their care or treatment through a range of informative leaflets, the practice also used models, for example of the human lung, to show patients aspects of the problem or treatment. The patient record system used by the practice enabled GPs to print out relevant information for the patient at the time of the consultation, for example where a patient received a new diagnosis.

Patient/carer support to cope emotionally with care and treatment

There was support and information for patients and their carers to help them cope emotionally with their care, treatment or condition. There was written information available for carers to help ensure they understood the various avenues of support available to them. There were notices in the waiting room informing patients how to access a number of support groups and organisations.

The GPs carried out home visits to patients who were housebound or receiving end of life care. There were end of life care plans which included ensuring that urgently needed medicines were issued without delay. How to follow up with families who had suffered bereavement, was decision for individual GPs. Usually this took the form of a

Good

Are services caring?

telephone call to the family and the offer of consultation, at a flexible time and location to meet the family's needs. Where appropriate the bereaved were offered counselling with a reputable national charity specialising in this service. There was a system for informing all staff, privately, when a family had suffered bereavement so that they could provide a sympathetic and helpful response.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood and there were systems to address identified needs in the way services were delivered. For example, the practice saw from surveys and responses to reviews on the NHS Choices website that difficulty in getting through to the practice on the telephone was an issue of concern to patients. The practice had installed an additional telephone line and during the busy morning period had made more staff available to answer the telephones.

We saw that the practice worked with the local clinical commissioning group (CCG) for example in developing care packages and services for patients diagnosed with dementia.

The practice had an active patient participation group (PPG). We spoke with the chair of the group. The chair reported that the practice was very supportive of the group. The practice manager attended the PPG meetings. We saw that there was no attendance at the PPG meetings by a GP partner. The PPG felt that this did not reflect the high regard in which the practice held its PPG. The PPG had surveyed the patients and identified several concerns. One concern had been the inflexibility of the appointment system which only permitted appointments to be booked two weeks in advance. This was not sufficiently responsive to patients' needs, the practice had consulted with the PPG and changed the system to allow for a wider range of appointment types and more urgent appointments. Appointments could now be booked up to twelve weeks in advance.

Tackling inequity and promoting equality

There were facilities so that patients with disabilities could access the practice. 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 and baby changing facilities. 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; therefore patients could choose to see a male or female doctor. The practice was in an area of considerable national diversity though the majority were English speaking patients. There was access to translators, online and telephone translation services. There were staff at the practice who spoke Polish, Russian, German, Hindi, Marathi, Punjabi and Urdu.

There was a register of patients who had illnesses which made them particularly vulnerable, for example a learning disability, dementia or end of life care. When staff accessed the notes of such patients a message was displayed on the computer screen to inform the staff member of the diagnosis. Thus they were better able to manage their interaction with that person by taking into account any difficulties that the patient might have, such as difficulties in communication, memory or understanding.

Access to the service

Primary medical services were provided Monday to Friday between the hours of 8.30am and 6.pm. There were evening surgeries from 6.30pm to 7.30pm twice a week. This was for appointments only and was designed to cater for patients who found it difficult to get to the practice during normal working hours. The switchboard was closed during lunchtime from 1pm to 2pm. There were six appointments set aside for patients with "urgent on the day" problems.

There were pre-bookable appointments, up to 12 weeks in advance, and appointments available on the day. There were telephone consultations available, on the day, for patients where this was appropriate. Older people requiring urgent care were seen on the day either as an emergency appointment or in a home visit if the person was housebound, in a care home or too unwell to attend. Children who called with urgent matters were seen as soon as possible and, in any event, on the day the parents called.

Information was available to patients about appointments in the practice leaflet and through the internet using NHS Choices. This included how to arrange urgent appointments and home visits and how to book appointments. There was electronic booking of appointments. There were also arrangements for patients to receive 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for patients who needed them and those with long-term conditions. There was a protocol to guide staff on a range of standard longer appointments. Nurses conducted reviews at patients' homes (or nursing homes) when this was necessary.

Other patients, such as those with mental health problems could ask for longer appointments. We heard reception staff booking these appointments and they accommodated patients' needs when possible. Patients who had a care plan had priority in the allocation of appointments and the computer system alerted reception staff to these patients when appointments were made.

We reviewed the most recent data available from the national patient survey concerning patient satisfaction about access to the service. The results were mixed. Only 42% found it easy to get through to the practice by phone, the national average was 72%. Only 45% describe their experience of making an appointment as good, the national average was 73%. On the other hand 80% were able to get an appointment to see or speak to someone the last time they tried (national average 86%) and 90% said the last appointment they got was convenient (national average 92%). Given the low number of patients returning the surveys these last two results were not significantly different statistically. Since the survey the practice had upgraded the telephone system and increased the number of staff available to answer the telephones. They had changed the appointment system and introduced a triage system to improve the flow of patients through the practice. The practice had not yet tested whether these changes had led to the improvements desired.

Listening and learning from concerns and complaints

There was a complaints policy which included the timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage complaints. Information was available to help patients understand the complaints system. There were leaflets, notices and material on the practice information leaflet. 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, however all felt that if they had to make a complaint they would be listened to and the matter acted upon.

We looked at the record of complaints. Complaints were well recorded and there was a record of a thorough investigation which identified the issues. However evidence of learning from complaints was sparse. There were comments such "complaint discussed". There was no evidence of when or amongst whom the matter was discussed. Some complaints, which were clearly significant events, were not recorded as such. Therefore lessons which might have applied across the practice were restricted to those involved only in the complaint. For some complaints there was clear learning. For example a secondary referral had been sent to a hospital but was not recorded, by the hospital, as being received. As a result of the subsequent complaint the practice introduced new dictation software which also tracked the progress of the referral.

Complainants were offered an apology where the circumstances warranted it. Complainants were referred to the Health and Parliamentary Ombudsman if the matter could not be resolved and the practice complaints policy reflected this.

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 leadership explained that, in the past, the practice had failed to keep up with the changes that were impacting on general practice. This had included failing to change staff working practices and failings in financial management. This had culminated in October 2013 with a change in the partnership and leadership at the practice.

A new practice manager had been employed and there had been a considerable change in staff and practices. Staff were aware of and involved in the changes. The staff we spoke with told us they felt well led and described a practice that was open and transparent. Patients that we spoke with described a practice, and particularly a reception area, that was more relaxed and helpful than in the past. Staff consistently said they understood the practice objective namely to provide patient centred care regardless of the patient's social standing or income and to deliver care locally. The GPs and the manager said they advocated an "open door" policy and all staff told us the GPs and practice manager were very approachable.

There had been discussion amongst the GPs and staff about the strategic direction of the practice and there had been discussions with other health professionals about how the practice might develop. Some decisions had been taken, for example the practice was a GP member of Invicta Health, a community interest company. Membership supported the practice's aim of offering the patients as wide a range of services as possible and of bringing suitable secondary care into practices.

Governance arrangements

There was a range of mechanisms to manage governance of the practice. There were policies and procedures that governed activity and guided staff. These were available to staff on the desktop on any computer within the practice. We looked at some of these including recruitment, induction, safeguarding, complaints and repeat prescribing. There was evidence that staff had read the policies. The policies we looked at were in date and had dates assigned for their review.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a lead for safeguarding, for education and for human resources. Staff knew who the leads for the roles were and were confident in approaching them if necessary. Staff told us that they felt involved in the changes that had happened since the new partnership took over the running of the practice. They said they were informed through regular discussion with the practice manager and through staff meetings.

We were told that the GPs regularly talked through difficult cases with each other and there had been changes to the care that individual patients received as a result of this. There were two formal clinical governance meetings annually. There was evidence of change and improvement from the meetings; these had included the purchasing of and training on dictation software that also tracked the patients referrals to secondary care and appointing a designated member of staff to ensure that six to eight week baby checks were arranged, conducted and monitored correctly.

A number of audits had been started since the new partnership in October 2013. These included an audit of family planning services and an audit of vitamin B12 to improve the identification and treatment of patients who were deficient. In each case there was only one cycle of the audit completed. Other audits were more in the nature of reviews of medication following safety and other alerts though we saw that these were done effectively. There was no audit plan and no evidence that subjects for audits were being selected on the basis of the impact that the audit would have on the practice's identified population groups.

The practice used the Quality and Outcomes Framework (QOF) to monitor the effectiveness of the care and treatment provided to patients. Some QOF results, such as those that reflected the practice's diagnosis of specific diseases and conditions, were excellent. In other areas, such as the numbers of patients receiving regular health checks for common conditions for example hypertension and diabetes, the results were disappointing. The practice was aware of this. A partner had been delegated to monitor and to improve the QOF results and we saw from recent results this was already having an impact. The practice had instituted Saturday morning clinics and extra staff to achieve this.

There had been partners' meetings since the new partnership was formed, however they were informal and were not minuted.

Are services well-led?

Good

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

There was peer review of GPs decisions such as referrals to secondary care. For example the peer review identified that the practice had had a high rate of orthopaedic referrals. Since then the practice has started in-house joint injections and physiotherapy sessions. This was consistent with their vision of providing local care. It had resulted in reduced referrals to secondary care. The practice had worked with the prescribing advisors from the clinical commissioning group (CCG) and agreed actions to be taken to the prescribing patterns of certain medicines such as opiates and anticonvulsants.

The practice had arrangements for identifying, recording and managing risks in relation to the premises and its staff. Routine checks were undertaken and any risks were identified and recorded. Risk assessments had been undertaken, for example, a fire risk assessment. The practice regularly monitored the premises itself and this included processes and procedures in relation to patient safety and the general management of the practice. For example an assessment of the risks associated with the use of the building's lift and regular checking of the fire extinguishers.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and comments about the practice. Receptionists we spoke with said they would interrupt a consultation if they had an urgent concern and GPs supported this. Staff had job descriptions that clearly defined their roles and tasks at the practice. All staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care. Staff had responsibility for different activities for example, checking on QOF performance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies; for example disciplinary procedures, training and confidentiality, all intended to support staff. There was a handbook that was available to all staff, which included sections on equality and harassment and bullying at work. The practice had a whistleblowing policy. Staff we spoke with knew where to find these policies if required. Staff also told us about the staff social events they attended. There were three or four events annually and staff felt these events helped to break down barriers between different sections of the practice, making everyone more approachable.

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

Staff we spoke with felt that the practice was open to suggestions from staff. They said they were made aware of comments and planned changes through regular emails and meetings with the practice manager. The staff had been instrumental in suggesting changes to the way that correspondence in and out of the practice was monitored and checked following an incident where some correspondence had not been actioned. We were told that the practice had responded to patients' suggestions concerning the management of the telephone system and the way appointments were made within the practice. The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. For example following the patient survey the practice was trying to improve the continuity of care by employing salaried GPs. They had already made some improvements to this by using regular locum GPs.

Management lead through learning and improvement

The practice GP and nursing staff accessed on-going learning to improve their clinical skills and competencies, for example, by attending the training sessions in regular protected learning time that was provided by the clinical commissioning group and other training opportunities. One GP told us of the changes to anticoagulant medicine they prescribed following a training event from a follow GP with a special interest in cardiology. Nursing staff attended external forums and events to help ensure their continued professional development, one nurse had recently received training in starting insulin administration for diabetic patients. All staff had protected learning time during the monthly half-day closure of the practice set aside for learning and development.

Administrative staff told us that the practice supported them in their personal development, for example there had been training in information governance and chaperoning in the recent past.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider failed to establish and operate effectively systems to:** **assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)** Because: 1. There was no systematic approach to reporting, recording and monitoring significant events, incidents and accidents, 2. Clinical and other audits were incomplete.