

# B Biswas and P Ray

## Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	5
What people who use the service say	7

### Detailed findings from this inspection

Our inspection team	8
Background to B Biswas and P Ray	8
Why we carried out this inspection	8
How we carried out this inspection	8
Detailed findings	10

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Blundell Park Surgery on 6 January 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The practice actively sought the opinions of staff and patients, working with a well-established patient participation group (PPG).

**Professor Steve Field (CBE FRCP FFPH FRCGP)**  
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's 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.

Good



### Are services caring?

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



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

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 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

Good



# Summary of findings

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 with staff and other stakeholders was evident.

## Are services well-led?

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.

**Good**



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people. Nationally reported data showed that 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.

Good



### People with long term conditions

The practice is rated as good for the care of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews 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.

Good



### Families, children and young people

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 that 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.

Good



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

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

Good



# Summary of findings

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

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.

Good



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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 100% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary 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.

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. Staff had received training on how to care for people with mental health needs and dementia.

Good



# Summary of findings

## What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete.

We received five completed CQC comment cards and spoke with 4 patients who were attending the practice on the day of inspection. We spoke with people from different age groups, including parents and children, patients with different physical conditions and long-term care needs. The patients we spoke with were extremely complimentary about the staff and clinicians, as were all of the care quality commission comment cards. Patients told us they found the staff to be very helpful and felt they were treated with respect.

Findings from the 2014 Patient Survey indicated a high level of satisfaction with the care and treatment provided by the practice;

68% of respondents could see a GP urgently on the same day

93% of respondents could easily book an appointment ahead

91% of respondents said the GP gave them enough time

98% of respondents were treated with care and concern by the nurse

# B Biswas and P Ray

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector**.  
The team included a GP and a Practice Manager.

## Background to B Biswas and P Ray

Blundell Park Surgery is situated on Grimsby Road, Cleethorpes. The registered patient list size is 2431. Within this there are 154 patients aged 0 to 5 years, 404 patients aged six to 18 years, 1557 patients aged 18 to 65 years, 418 patients aged over 65, out of which 180 are over 75 years. The practice is a partnership and has a female and a male GP. There are practice nurses and health care assistants. The practice has a practice manager, receptionists and administration staff.

A full range of general practice services are provided and there is access to services such as; physiotherapy, podiatry, psychology, a dietician and an outreach consultant psychiatric clinic.

The practice has a general medical services (GMS) Contract under section 84 of the National Health Service Act 2006. The NHS Commissioning Board and the practice enter into a general medical services contract under which the practice is to provide primary medical services and other services in accordance with the provisions of the Contract.

When the practice is closed an answerphone directs patients to telephone another number for out of hours care.

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- 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



# Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 06 January 2015

During our visit we spoke with a range of staff including a GP, the practice manager, a practice nurse, a healthcare assistant and reception staff.

We spoke with five patients who used the service and reviewed four CQC comment cards where patients were able to share their views and experiences of the service. We observed how people were being cared for and talked with carers and/or family members.

# Are services safe?

## Our findings

### Safe track record

When we first registered this practice in April 2013 the practice did not declare any safety concerns that related to how it operated. The information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. We had not been informed of any safeguarding or whistle-blowing concerns relating to patients who used the practice. The local CCG told us they had no concerns about how this practice operated.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, we saw that a patient's test result had not been followed up by the practice and a new policy for hospital correspondence and results handling was put in place. A record of actions following results was put in place and checked weekly by the practice's administrator.

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

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of ten significant events that had occurred during the last year and we were able to review these. A significant incident was discussed at a pre-arranged meeting. The practice used agreed action plans to monitor learning and improvement. These actions plans were discussed and reviewed at agreed times. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by email 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 staff meetings.

### 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 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 lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. 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's 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 a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

## Are services safe?

The practice was able to identify families, children, and young people living at risk or in disadvantaged circumstances, and looked after children (under care of the Local Authority).

The clinical staff confirmed they were able to identify and follow up children, young people and families. There were systems in place for identifying children and young people with a high number of A&E attendances. Child protection case conferences and reviews were attended by staff where appropriate. We were told that children who persistently fail to attend appointments for childhood immunisations were followed up with letters and discussed with the health visitor.

We saw that staff were aware of and responsive to older people, families, children and young people, vulnerable people and the support they may require. The practice had good awareness of the support organisations in and around the area where patients could receive further support. This included direct links with the local authority and benefits agencies.

The practice had processes in place to identify and regularly review patients' conditions and medication. There were processes to ensure requests for repeat prescribing were monitored by the GPs.

The lead safeguarding GP was aware of vulnerable children and adults and demonstrated good liaison with partner agencies such as the police, social services and support organisations.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses received appropriate training to administer vaccines.

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

### 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.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed the findings of the audits were discussed.

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 and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in

# Are services safe?

contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

## Equipment

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

## Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that 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.

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 that actual staffing levels and skill mix were in line with planned staffing requirements.

## Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management,

staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was available to staff on the practice computer system.

Identified risks were included on a risk log. Risks were assessed and mitigating actions recorded to reduce and manage the risk. We saw risks and concerns were discussed at the practice meetings. For example, we saw the safe handling of patient specimens brought to the practice had been discussed and reviewed with the team.

Staff were able to identify and respond to the changing risks to patients including deteriorating health and well-being or medical emergencies. We saw that for all patients with long term conditions there were emergency processes in place to deal with their changing conditions. The nurse we spoke with told us that if a patient's condition is deteriorating they would increase the frequency of appointments and discuss with one of the GPs.

There were emergency processes in place for identifying acutely ill children and young people, and staff gave us examples of referrals they made. The practice had appropriate equipment in place to deal with medical emergencies for all patient groups.

The staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

The practice monitored repeat prescribing for people receiving medication for mental health needs and this was scheduled as part of their annual review.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The staff we spoke with were confident about dealing with emergencies.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and

## Are services safe?

hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that 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 a heating company to contact if the heating system failed.

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

Risks associated with service and staffing changes (both planned and unplanned) were in place.

# 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 minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they 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 continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed this happened.

The practice reviewed all aspect of the service both clinical and non-clinical. Examples of these were patient survey results, appointments attended and referrals sent. Examples of the monitoring of clinical serves were (Quality Outcome Framework) (QOF) unplanned admissions, prescribing and vaccinations. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw there were processes in place to review patients recently discharged from hospital, who required to be reviewed by their GP.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. Both GPs we spoke with used national standards for the referral of patients to secondary care and patients with suspected cancers who needed to be referred

and seen within two weeks. We saw evidence that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that 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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and 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 showed us two clinical audits that had been undertaken in the last two years. Both of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The two audits we looked at were a review of the NICE guidance on Heart Failure and audit prescribing in those patients with heart failure and an audit of minor surgery joint injections.

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). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had an annual



# Are services effective?

## (for example, treatment is effective)

medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected 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, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, 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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

### 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 fire and basic life support. We noted a good skill mix among the doctors with number having additional diplomas in family planning, woman's health and substance misuse. Both GPs were up to date with their yearly continuing professional development requirements and 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which goals and objectives were

documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, enhanced services for learning disabilities.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and review of patients with long term conditions. Those nurses with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

### Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x ray results, and letters from the local hospital including discharge summaries, from out-of-hours GP services 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 communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice had a process in place to follow up patients discharged from hospital. The practice undertook a regular review to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

### Information sharing

The practice used several electronic systems to communicate with other providers to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, through the

# Are services effective?

## (for example, treatment is effective)

Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments). Staff reported that this system was easy to use.

The practice has also signed up to the electronic Summary Care Record. The practice had in place a medical records system which allowed the clinical and the patients care teams instant access to medical records at all of their surgeries. This system enabled staff in the practice to see and treat patients from other practices registered within the group. These 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 in place to provide staff with the patient 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 that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

### Consent to care and treatment

We found that 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 to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had a processes in place to help staff, for example with making do not attempt resuscitation orders. This highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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 plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). 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 Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

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 relevant risks, benefits and 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

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

The practice asked new patients to complete a new patient registration form and there was a separate form for children under six years. The practice may then invite patients in for an assessment with one of the clinical staff. The registration form was detailed and asked the patients how they would prefer to communicate with the practice. This provided the practice with an opportunity to promote different methods of communication such as electronic communication. The GPs were informed of all health concerns detected and these were followed up in a timely way.

We were told that GPs and nurses used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic screening to patients and offering smoking cessation advice to smokers.

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 and they were offered an annual physical health check. Similar



# Are services effective?

(for example, treatment is effective)

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.

We saw evidence that the practice had systems in place to recall patients to the practice or to share health information with them, for a range of areas; for example cervical screening refusal, health checks for carers, thyroid, coil checks and rheumatoid arthritis review.

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 all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders.

The practice kept a register of patients who are identified as being at high risk of admission, or at end of life and had up to date care plans in place for sharing with other providers. We saw that patients in this group were followed after admissions and the practice used resources available to prevent readmission. Examples of these were the development of care plans where needed and working with the community support team. We saw that people received regular structured annual medication reviews for polypharmacy. All patients over 75 had a named GP.

People with long term conditions received a structured annual review for various long term conditions (LTC). Examples of these are Diabetes, COPD, Asthma and Heart failure.

We saw the practice regularly reviewed and monitored patient records using the electronic patient records. Examples of these were monitoring new cancer diagnoses, annual reviews with medicines management and cervical screening final non responders. The practice regularly monitored the palliative and safeguarding registers which were discussed at the monthly clinical and multidisciplinary management meetings.

There were comprehensive screening and vaccination programmes which were managed effectively to support children and young people. Staff were knowledgeable about child protection and safeguarding. The practice had processes in place to monitor any non-attendance of babies and children at vaccination clinics and worked with other agencies to follow up any concerns.

We saw the practice was aware of people whose circumstances may make them vulnerable. The practice holds a register of those in various vulnerable groups, such as learning disabilities.

People experiencing poor mental health in the practice had access to services. We saw that people with severe mental health problems received an annual physical health check. We saw staff had undertaken additional training in mental health and addiction. There was a good understanding and evidence of signposting patients to relevant support groups and third sector organisations operating in the local area.

# Are services caring?

## Our findings

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey October 2014, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and they 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 five 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 that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was shielded by glass partitions which helped keep patient information private.

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

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that 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 responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 92% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area. The results from the practice's own satisfaction survey showed that 93% of patients said they were sufficiently involved in making decisions about their care.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

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

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 85% of respondents to the Patient Participant Group survey said they had received help to access support services to help them manage their treatment and care when it had been needed. 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 that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website informed patients how to access a number of support groups and organisations. The practice's computer system

## Are services caring?

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.

# 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 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 that needed to be prioritised.

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). Examples of these were the introduction of making appointments online and to increase flu immunisation uptake in the over 65's and under 65's chronic disease patients.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

They recognised those with a learning disability, hearing loss, students, carers and the older population.

The practice had a hearing loop and access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training. The staff we spoke with were very aware of the importance of equality and diversity.

The premises and services had been adapted to meet the needs of people with disabilities. All areas of the practice for patients were accessible to people with disabilities.

The practice was situated in a two storey building which had been converted from two terraced houses. The consulting rooms and treatment rooms were on the ground floors. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

### Access to the service

The surgery was open Monday to Friday from 8am to 6:30pm with an extended surgery until 7:30pm every Wednesday for those patients who found it difficult to fit in with normal surgery times. They operated a mixed system of booked and open consultations. Bookable appointments were available in the mornings from 9am to 12 mid-day and there was a walk in clinic in the afternoons from 3pm to 5pm where patients without an appointment could wait and be seen by the GP available.

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 in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to the local care homes. Both GPs undertook this role in the practice.

Patients were generally satisfied with the appointments system. They confirmed they could see a doctor on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

### Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Posters were displayed in the waiting area and information was also in the

## Are services responsive to people's needs? (for example, to feedback?)

practices' summary leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last twelve months; They had all been handled satisfactorily, dealt with in a timely manner and to the satisfaction of the patient concerned.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. In the patient information leaflet it stated 'The practice will strive to maintain and improve the range and quality of service provided to our patients'. The practice also set out 'expectations' the practice aims for. For example a caring attitude to patients' problems and a willingness to work with the patient to resolve their problems.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw and were told that staff regularly came together at a range of formal meetings to discuss practice business, training, future developments and patients ongoing care.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at ten of these policies and procedures. They had all been reviewed annually and were up to date.

The practice held regular governance meetings. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed.

The practice used QOF to measure their performance. For 2013/2014 the QOF figure was 99.4% (for the points available to the practice). We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. We also saw the practice regularly reviewed documentation and shared with staff throughout the year. Examples of these include how many new patient records were processed, letters actioned and processed and any backlogs in the system. We also saw the practice completed regular searches to ensure they were dealing with information in a timely manner, such as searching for any laboratory results not filed.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had suitable arrangements in place for identifying, recording and managing risks. For example, an up-to-date fire safety risk assessment was in place, and there were risk assessments to minimise the risks associated with the use of IT equipment.

### Leadership, openness and transparency

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

We saw from minutes that team meetings were held regularly, at least 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, induction policy, management of sickness, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, this included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

### Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We were shown a report on comments from patients from an annual survey completed in June 2013. Some patients had said the waiting times to see a Doctor was too long. From that, the next survey questions were to be split into two types of appointments, booked and the walk in clinic. This would enable the practice to get a clearer picture of waiting times and be able to consider their changes.

The practice had an active patient participation group (PPG) which included representatives from various population groups; including older people and working age adults. The PPG had supported surveys and met every

# Are services well-led?

Good 

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

quarter. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

## 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 five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings, and minutes showed these events were discussed, with actions taken to reduce the risk of them happening again. Staff we spoke with referred to the open and honest culture within the practice and the leadership's desire to learn and improve outcomes for patients.