Dr R Khanchandani's Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr R Khanchandani's Practice on 12 November 2014.

The practice achieved an overall rating of Good. This was based on our rating of all of the five domains. Each of the six population groups we looked at achieved the same good rating.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- 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 should:

- Ensure staff are up-to-date in role specific safeguarding training
- Introduce suitable measures to audit the effectiveness of the infection control policy
- Ensure the cloth covered chairs in the waiting room at the Link Surgery are replaced as per the practice's recently agreed replacement programme
- Ensure all staff are familiar with fire evacuation procedures
- Make available written information for carers to ensure they understood the various avenues of support available to them
- Check that the learning points implemented from the analysis of significant events has had the desired effect and changed clinical care and practice

Summary of findings

- Monitor the newly introduced documented system at the Link Surgery so medicines are stored securely and kept at the required temperatures

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?

Good

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.

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. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. 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. 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.

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. 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. 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.

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

Summary of findings

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 reference group (PRG) was active. Staff had received 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. 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 a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were in line with national trends 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 and health visitors.

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.

Summary of findings

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 and those with a learning disability. It had carried out annual health checks for people with a learning disability. 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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with five patients and one member of the patient reference group (PRG) during our inspection. We reviewed comments from 11 CQC comment cards which had been completed, data from the National GP Patient Survey 2014, and results from the patient survey undertaken by the practice and Healthwatch Luton.

Patients told us that they were always treated with dignity and respect. The GPs in particular were noted for their compassion and care in providing treatment. We were told that the GPs and nurses explained procedures in detail and in a way that patients could understand. Many patients commented that access to appointments was an issue, but they told us that the practice had listened to feedback from patients and the PRG and recently changed their appointment system to provide better access to appointments.

The comment cards reviewed were mostly positive and said staff were helpful in addressing their care needs. Negative comments related to accessing appointments. A virtual PRG was in place. This group was a way for patients and staff to work together to improve services, promote health and improve the care experience. A member of the group told us that the practice acted on the suggestions made by the PRG made changes to the service where possible.

Data from the National GP Patient Survey and the practice survey showed patients were generally happy with the quality of the consultations but access to appointments remained an issue.

Areas for improvement

Action the service SHOULD take to improve

- Ensure staff are up-to-date in role specific safeguarding training
- Introduce suitable measures to audit the effectiveness of the infection control policy
- Ensure the cloth covered chairs in the waiting room at the Link Surgery are replaced as per the practice's recently agreed replacement programme
- Ensure all staff are familiar with fire evacuation procedures
- Make available written information for carers to ensure they understood the various avenues of support available to them
- Check that the learning points implemented from the analysis of significant events has had the desired effect and changed clinical care and practice
- Monitor the newly introduced documented system at the Link Surgery so medicines are stored securely and kept at the required temperatures

Dr R Khanchandani's Practice

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 acting as specialist advisers.

Background to Dr R Khanchandani's Practice

Dr R Khanchandani's Practice situated at the Blenheim Medical Centre provide a range of primary medical services to patients who live in Bury Park and surrounding areas near the town centre of Luton in Bedfordshire. The practice has a registered population of approximately 11500 patients. There is a branch, The Link Surgery, which serves patients who live in the Hockwell Ring area of Luton. The population is predominantly from the Asian Pakistani and Polish communities. Patients can access any of the branches to see a GP or obtain the other services provided.

Clinical staff at this practice includes four GP partners, two salaried GPs, three GP registrars, two nurse practitioners, and two healthcare assistants. Management, administration and reception staff support the practice. Community nurses, health visitors and a midwife from the local NHS trusts also provide a service at this practice.

Out of hours care when the surgery is closed is through the NHS 111 service.

Why we carried out this inspection

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

We carried out 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.

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

How we carried out this inspection

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. These groups are:

Older people

Detailed findings

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We spoke with the local Clinical Commissioning Group (CCG), the Local Medical Committee (LMC) and NHS England. We carried out an announced visit on 12 November 2014 and inspected the Blenheim Medical Centre and the Link Surgery. Please note the reference to 'the practice' in this report concerns both the above practices unless a specific reference is made to a particular practice.

During our visit we spoke with a range of staff, including GPs, reception staff, nurses and the practice manager. We spoke with patients who used the service. We observed how patients and family members were dealt with and collected comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff had reported an incident where a test result had been filed incorrectly and we saw that the practice had taken corrective action in a timely way.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the past year and we were able to review these. Significant events was a standing item on the practice team meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff were aware of the procedures to follow when reporting a concern or incident. They told us they were encouraged to report incidents so all could learn from them. We found that there was a positive culture amongst the managers and staff to report incidents to keep both staff and patients safe. We saw evidence of action taken as a result. For example the practice had taken action to ensure patients were given sufficient take home medications on discharge by the hospital when they were alerted by the patient that this had not happened. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National Patient Safety Alerts were responded to in a timely fashion. GPs clinical and other staff were informed of the relevant issues with adjustments made to care and treatment where necessary.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff we spoke with told us that they had received relevant role specific training on safeguarding. Medical, nursing and administrative staff we spoke with 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. We saw that some staff required safeguarding training updates. The practice manager told us that this training was being arranged.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. All staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. We saw that the practice team had regular communications with the health visitor, and other clinical and relevant staff to discuss on going safeguarding issues and agree plans for keeping patients safe. The safeguarding lead generally did not attend child protection case conferences and reviews but sent relevant information to these meetings.

There was a chaperone policy and staff had received appropriate training to act as a chaperone.

Medicines management

At the Blenheim Medical Centre we checked the medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were instructions for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed these instructions. These arrangements were not evident at the At the Link Surgery. Following our inspection the practice manager wrote to us and told us that they had

introduced a documented system at the Link Surgery so medicines were stored securely and kept at the required temperatures, including the action to take in the event of a potential failure.

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.

A review of prescribing data, for example, patterns of antibiotic and hypnotics and sedatives prescribing within the practice showed that performance was in line with national trends.

Staff told us that vaccines were administered using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. At the Blenheim Medical Centre individual blank prescription sheets were tracked and kept securely at all times. At the Link Surgery we did not see a system to track and keep blank prescription sheets safe. Following our inspection the practice manager wrote to us and told us that blank prescription sheets were now kept locked and they had implemented a system to track these and keep them safe. We will look at this at our next inspection of the practice.

Cleanliness and infection control

We observed the premises to be clean and tidy. At Blenheim Medical Centre we saw there was cleaning schedules in place and cleaning records were kept. However cleaning schedules and records were not evident at the Link Surgery. Following our inspection the practice manager wrote to us and told us that they had remedied this and awarded the cleaning contract to a private company and now had cleaning schedules and records. Patients we spoke with told us they always found both 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 had received an update during a protected learning time session in 2013. We did not see evidence of a recent infection control audit. The practice manager told us that the most recent infection control audit had been conducted by the former NHS primary care trust quality monitoring team and the practice had acted on the recommendations. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Chairs in the waiting room at the Link Surgery were covered with cloth. We did not see a regular cleaning programme to keep these chairs clean. Following our inspection the practice manager wrote to us and told us that these chairs will be reupholstered with a wipe clean material over the next few months.

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, The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. We saw that storage containers for used syringes and needles were labelled correctly and not overfilled.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum at the practices.

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

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) for applicable staff. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. While non clinical staff did not routinely have a DBS check we did not see a risk assessment on the employees file giving the reason why. Following our inspection the practice manager wrote to us and told us that they had introduced a system to risk assess non clinical staff for the need for a DBS check and had carried out this check for all recent employees.

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 patient services manager checked actual staffing levels and skills were checked against the planned staffing requirements and made adjustments to staffing needs on an on going basis.

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, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Hazards were identified using a standard template which identified the risk with mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

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 and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment at both practices. Records showed that all staff had received training in basic life support.

We saw records at Blenheim Medical Centre that confirmed emergency equipment was checked regularly. Emergency medicines were available in a secure area of Blenheim Medical Centre and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

At the Link Surgery similar emergency equipment and medicines were available but we did not see any evidence that showed that these have been checked regularly for their readiness for use or to ensure relevant medicines had been stocked. Following our inspection the practice manager wrote to us and told us that the emergency medicine stocked at the Link Surgery was now as recommended by the resuscitation council guidelines and emergency medicines and equipment were now checked regularly. We will look at this at our next inspection of the practice.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. 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.

Good

Are services safe?

The practice had carried out a fire risk assessment for appliances that included actions required to maintain fire safety. Records showed that staff were up to date with fire training through e-learning. There had been no fire drills for several years.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

A GP told us that relevant new guidelines and its implications for the practice's performance and patient care were discussed during monthly clinical meetings and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that 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, asthma and Chronic obstructive pulmonary disease (COPD), women's health and psychiatry. 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 that this happened.

We reviewed the data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices.

We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs 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

The practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a national performance measurement tool. GPs reported that this data had always shown they performed well and the GP's view was that QOF drove good patient care and they would continue the work regardless of financial incentive.

The practice had a system for completing clinical audit cycles. These were quality improvement processes that aimed to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local CCG initiated audits. We saw two recent examples of these at the practice which related to long term pain relief prescribing, and the treatment of menorrhagia (heavy periods). Both had been completed.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 85% of patients with diabetes had foot examination, and the practice met all the minimum standards for QOF in diabetes and chronic obstructive pulmonary disease (lung disease).

The practice had a palliative care register and had regular internal as well as multidisciplinary case review meetings where the care and support needs of patients and their families were discussed

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed a training matrix that recorded staff training needs and training attended and saw that all staff were up to date with attending mandatory courses such as annual basic life support.

We saw that appraisals had taken place and included a process for further review of identified learning needs and targets made during appraisals. Staff we spoke with said they were being supported to access relevant training that enabled them to confidently and effectively fulfil their role.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, practice nurses seeing

Good

Are services effective?

(for example, treatment is effective)

patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD), were able to demonstrate that they had appropriate training to fulfil these roles and had attended protected time learning sessions or dedicated training.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. All GPs had a scheduled programme for revalidation or had been revalidated. The practice nurses were supported to attend updates to training that enabled them to maintain and enhance their professional skills.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

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, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear mechanisms to make such referrals in a timely way and this ensured patients received effective, co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine.

The practice held regular multidisciplinary team meetings 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 district nurses, palliative care nurses and decisions about care planning were documented in a shared care record. They also liaised with the out of hours service and provided detailed clinical information about patients with complex healthcare needs.

All patient contacts with the out of hours provider were reviewed by the GP the next working day. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

There was effective communication, information sharing and decision making about a patient's care across all of the services involved both internal and external to the organisation, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

Electronic systems were also in place for making referrals, and the practice made use of the Choose and Book system for making referrals. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

The practice had a system to communicate with other providers. We saw evidence of information sharing, for example with the out of hours service, palliative care team and the Macmillan service. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. There were arrangements to receive hospital summaries of recently discharged patients. These were scanned and directed to the relevant GP for their review and any follow up action.

Consent to care and treatment

The practice had policies and procedures concerning gaining consent from patients and staff told us they were aware of the need to accurately record all patient consent when it was given either verbally or in writing.

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation.

Good

Are services effective?

(for example, treatment is effective)

Nurses and GPs we spoke with demonstrated clear understanding of Gillick competence. Gillick competence refers to a child under 16 who is able to demonstrate they are capable of making decisions and give consent to care and treatment without parental consultation.

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. Clinical staff we spoke were knowledgeable about how a patient's best interests should be taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

Patients told us that they were given written and verbal information about their conditions which included advice on healthy lifestyles. They told us that the GPs and nurses made sure they understood their conditions and gave us examples of how GPs had clearly explained their treatment to them and made sure they fully understood their diagnosis and treatment.

There were a variety of patient information leaflets available in patient waiting areas. There was support and guidance information signposting patients to local and national support groups such as Macmillan service, local carers and mental health support groups.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. GPs opportunistically used their contact with patients to help them maintain or improve their mental, physical health and wellbeing. For example, by offering opportunistic physical exercise programme, referral to counselling service 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 of all patients in need of palliative care and support irrespective of age.

The practice offered proactive diabetic care. For example 87% patients with diabetes had received a foot examination and risk classification within the preceding 15 months.

The practice's performance for cervical smear uptake was 77%, which was similar to other practices in the CCG area. Contraceptive care was provided by all the doctors and nurses during surgery hours.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice nurses had specialised skills and had received specific training to deliver a range of services for example treatment of diabetes, asthma, and chronic obstructive pulmonary disease related care.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received eleven completed cards and all but one were positive about the service experienced. Patients commented that staff were polite, helpful and gave them time to discuss their needs. They said the GPs were kind and caring and treated them with dignity and respect.

We spoke with five patients on the day of our inspection. They spoke positively about the care they had received, and said their dignity was always respected. They said the GPs treated them with compassion listened to their needs and explained their treatment options and felt well looked after. They particularly noted the fact that they could converse in their own Asian language with some GPs which made the consultation more personal.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey. This survey showed that 72% reported their GP was good at treating them with care and concern. This result is slightly lower in comparison with other GP practices in the local CCG area and contradicted what patients told us on the day of the inspection and the comments left for us in the comments card.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There was a clearly visible notice in the patient reception area and on the practice website 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

Information from the National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Data from the survey showed us that 65% of respondents found their GP was good at involving them in decisions about their care, which was slightly lower in comparison with other GP practices in the local CCG area. However a survey by Healthwatch Luton showed 79% of the patients thought they were involved in their care and treatment with a practice commissioned survey showing 85% involvement in care and treatment. The latter two results are similar to the CCG average of other practices in the local area. Eighty two percent felt the GP was good at explaining tests and treatments, which was higher than the local CCG average of 80%.

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. A number of GPs and nurses that worked at the practice also spoke the most common Asian languages which enabled patients to consult with the GPs in their own language.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards highlighted that staff responded compassionately when they needed help and provided support when required. We observed patients in the reception area being treated with kindness and compassion by staff.

The practice held a walk-in clinic three days a week where patients with acute illness including those that required emotional support were encouraged to attend. Where required patients were referred to emotional support services or signposted to support services such as bereavement counselling and MIND a mental health charity.

Notices in the patient waiting room, and on the practice website told people how to access a number of support

Good

Are services caring?

groups and organisations. Patients were encouraged to declare if they were carers when they registered and during consultations. The practice' computer system alerted GPs if a patient was also a carer.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

Staff we spoke with told us that they worked in a cohesive team which enabled them to provide a friendly and flexible service. Patients we spoke with told us receptionists were good at listening to them, were understanding and directed them to the right professional or service in a polite and friendly way.

The practice engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. For example the practice had explored with the CCG better ways of engaging with the local mental health services so patients with mental health needs received a better service.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PRG). For example the practice had implemented new software so the telephone system could be monitored daily allowing better telephone access to the appointment system. The practice had also recruited additional reception staff and trained them in using the new system.

The practice had responded to the needs of the practice population and operated extended hours on two different days at the main and branch surgery to ensure appointments were available for students, commuters and working people.

For families, children and young people, appointments were available outside of school hours. In addition the practice offered telephone consultations.

Older people who lived in care/nursing homes and housebound patients were offered home visits based on their specific need.

Tackling inequity and promoting equality

Staff were aware of patients for whom English was not their first language. They said they had a translation service if required but that most patients came with their own translator. A number of GPs and nurses that worked at the practice also spoke the most common Asian languages which enabled patients to consult with the GPs in their own language.

The practice had not arranged specific equality and diversity training. However the staff we spoke with had a good understanding of equality and diversity. Any specific issues were discussed at practice meetings and staff were actively asked for their opinions and views.

There were facilities for patients who used a wheelchair such as fully automated doors at the main entrance to the practice, same level flooring throughout, clinical and consultation rooms available on the ground floor and a toilet for patients with disabilities including grab rails and alarm. The practice had disabled parking available.

Practice staff told us they knew the patient list well and flexible appointments in terms of time and length of appointment times could be accommodated based on their specific needs.

The practice operated a policy to care for patients without stigma or prejudice. Homeless patients for example were able to register the same way as other eligible patients and the practice a flexible approach when providing to the needs of the individual.

Access to the service

At Blenheim Medical Centre appointments were available from 8am to 6.30pm Tuesday, Thursday and on Friday. On Monday appointments were available from 8am to 8pm. On Wednesday appointments were available 8am to 3.30pm but patients could request a telephone consultation until 6:30pm. There was also a walk-in clinic operated on Monday Wednesday and Friday morning when patients could attend without an appointment.

At the Link Surgery appointments were available from 8am to 6.30pm Monday, Tuesday and Friday. On Wednesday appointments were available from 8am to 8pm. On Thursday appointments were available 8am to 1.30pm but patients could request a telephone consultation until 6:30pm

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. Patients could book appointments through the web, but this access was only available to patient who had pre

Good

Are services responsive to people's needs?

(for example, to feedback?)

registered at the practice to use this service. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patient satisfaction with the appointments system was mixed. Information from the National GP survey, the Healthwatch survey and the practice's own PRG survey have shown that improvements were needed especially to the telephone booking system. We were shown evidence that the practice was acting on this.

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 available to housebound patients and to patients who lived in care or nursing homes. Patients we spoke with confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns and complaints

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

We saw that information was available in the patient waiting area to help patients understand the complaints system. 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.

A complaints log was kept and we reviewed the complaints received in the past year and found that these had been investigated and responded to in a timely manner. Staff told us that complaints received were discussed during practice meetings so they were able to learn and contribute to determining any improvements that may be required. We reviewed the minutes from practice meetings which showed evidence of discussion shared learning. Staff we spoke with were aware of the system in place to deal with complaints.

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. They stated their aim was to provide high quality, safe and effective services and environment. The intent was to provide this service to the whole population by creating a partnership between the patient and the healthcare professional that cared for them at the practice. Patients confirmed this was their experience.

We spoke with a number of GPs nurses and other staff and they all knew the provision of high quality care for patients was their main priority and knew their responsibilities in making this vision a reality.

Governance arrangements

There was a clinical governance policy. This policy gave details of the arrangements including how the practice would address clinical audit, evidence based medical treatment, staff and staff management, information and its use, continuous professional development, patient experience and strategic capacity. There was a designated GP responsible for its implementation.

The practice had a number of policies and procedures in place to govern activity and these were available to staff through the shared drive on any computer within the practice. We randomly looked at five of these documents and found that these had recent review date.

The practice used the quality and outcomes framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Clinical audits were regularly undertaken by the practice GPs. We were shown records of completed audits the practice had undertaken during the past twelve months. These included audits on long term pain relief prescribing, and the treatment of menorrhagia (heavy periods). As a result of these audits, further training and other changes had been identified and implemented.

The practice had a system for capturing any significant events that had occurred. The information from the significant events was analysed, reviewed and a clear action plan with learning points completed. However we were not shown evidence that the practice had subsequently checked that the learning points implemented had been effective.

The practice held regular staff, clinical meetings where performance and related governance issues were discussed. We looked at minutes of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice had a leadership structure with named members of staff in lead roles. For example there were named leads for safeguarding, infection control and clinical governance. Staff we spoke with were clear about their roles and responsibilities and were clear as to who their line manager was and who to go to for support. They told us they felt valued, well supported and knew who to go to if they had any concerns.

A hard copy and electronic version of the staff handbook was available to all staff, and included sections such as the annual appraisal process.

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the patient reference group (PRG), National GP Patient survey, in-house practice survey, and complaints received. The majority of the feedback related to patients satisfaction with the appointments system and access to a GP. As a result the practice had re-configured the telephone system allowing better access to the GP appointments. Additional reception staff had been recruited and trained in using the new system. A female GP was now available to improve access and the practice had introduced telephone consultation for those patients who wanted to make use of this facility.

We spoke with a member of the patient reference group (PRG). They told us that the group was now virtual with communication by e-mail or by post. Support from the practice was good and practice had responded well to

Are services well-led?

Good

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

suggestions made. For example improvements had been made to the flu vaccination campaign for the over 65 year-olds and the appointment system as a direct result of suggestions from the PRG. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PRG. The results and actions agreed from these surveys were available on the practice website.

Staff told us that there was an open culture within the practice and the practice meetings provided an opportunity to provide feedback. Staff also commented that the management team were approachable, and they could speak with them in private if they could not raise their concerns during practice meetings.

The practice had a whistleblowing policy which was available to all staff on any computer within the practice.