

# ICO Health Group - Chinbrook Surgery

## Quality Report

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

### Ratings

#### Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at ICO Health Group on 16 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, responsive caring and well-led services. It was good at providing services for all the population groups including older people; long term conditions; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health.

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. All opportunities for learning from internal and external incidents were maximised. Risks to patients were assessed and well managed.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local

providers to share best practice. Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

- 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.

# Summary of findings

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

Importantly the provider should

- Ensure patients with long term conditions such as diabetes are offered opportunistic screening when they fail to attend regular checks.

**Professor Steve Field** CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

**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. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



### Are services caring?

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

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

Good



# Summary of findings

## Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active PPG.

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 had a named GP for all patients over 75. All patients above 90 years and frail patients living alone, without long term conditions also received regular reviews. All patients at risk of falls and needing bone health treatment were referred for specialist care. The practice followed up older patients that were discharged from hospital following emergency admission and their care plans were constantly reviewed. Appointments were flexible to deal with emergencies and the practice had introduced a winter clinic to support older patients with emergency access. The practice arranged and held meetings with the district nurses, the end of life care team and the hospice on a regular basis.

Good



### People with long term conditions

The practice is rated as requires improvement 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. However, not all these patients with diabetes had received annual reviews to check that their health and care needs were being met despite staff having an opportunity to do so at opportunistic contacts.

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. 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.

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

Good



# Summary of findings

attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed

## **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 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.

Good



## **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 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). 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.

Good



# Summary of findings

## What people who use the service say

We received 25 Care Quality Commission (CQC) comment cards, which patients had used to express their views on the service. Of these, 24 contained positive comments relating to the service, access to GPs and the practice nurse, and the friendliness of reception staff. One card described areas of dissatisfaction, such as not being able to get through to the practice by phone at peak periods during the day. However all patients we spoke with were complimentary on the attitudes of all staff and reported feeling well cared for and respected. We did not have data on the gp patient survey specific for this practice. Data that was available was a combined of all the other locations operated by the Penrose Group.

Patients were complimentary about the practice with many comments referring to the helpful nature of reception staff as well as the listening skills and caring nature of clinicians at all levels. Patients reported being happy with the appointments system which they felt suited their needs.

We spoke with one representative from the Patient Participation Group (PPG). They told us that the practice welcomed comments and suggestions from them and they felt involved in many decisions relating to patient care.

## Areas for improvement

N/A

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

Ensure patients with long term conditions such as diabetes are offered opportunistic screening when they fail to attend regular checks.



# ICO Health Group - Chinbrook Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP specialist adviser and a practice manager. The GP advisors and Experts by Experience are granted the same authority to enter registered persons' premises as the CQC inspectors.

You should also be aware that experts who take part in the inspections, for example, Experts by Experience, are not independent individuals who accompany an inspection team – they are a part of the inspection team and should be described in that way. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

### Background to ICO Health Group - Chinbrook Surgery

ICO Health Group-Chinbrook is one of four practices operated by the ICO Health Group. The group represents the merger of four practices that occurred in 2013. The practices are all located in the Grove Park area of Lewisham. The practice provides general practice services to around 2300 patients within the NHS Lewisham Clinical Commissioning Group (CCG) area. Patients can be seen at any of the other three locations. NHS Lewisham is made up of 44 local GP surgeries. For our inspection we visited the Chinbrook surgery site only. All the locations are individually registered with the CQC.

Lewisham is a London borough in south-east London. In Lewisham deprivation levels are significantly worse than the England average. Demographic information for Lewisham shows the number of people between 20 and 39 and children under ten is significantly higher than the England average. Census data shows an increasing population and a higher than average proportion of Black and Minority Ethnic residents in Lewisham.

The Practice population is varied with a range of social classes and ethnic groups. The practice population has a higher proportion of younger adults and children and lower proportions of older people. The local area has relatively low levels of deprivation compared to the National average. The practice serves a culturally diverse population, with the majority of patients being Asian, African and white British. According to the practice they have a high number of young patients who are a highly mobile population.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostics and screening procedures; family planning; surgical procedures; maternity and midwifery services; and treatment of disease, disorder or injury.

The ICO group operates a rotational basis and staff work across all three sites. The Chinbrook surgery at any given time will have one full time GP, a practice nurse working 15 hours per week and two reception staff.

The surgery is open all day and core consulting takes place between 8.00am-6.30pm Monday-Friday. Early morning surgeries are offered on Monday, Wednesday and Thursday from 7.00am and late night surgeries on Tuesday,

# Detailed findings

Wednesdays and Thursdays from 6.30pm-8.30pm. The practice operates a routine pre-booked GP Saturday surgery from 9.00am-11.00am. All late nights and Saturdays also have appointments available with the practice nurse.

The practice has opted out of providing out-of-hours services to their own patients. A local out of hours service is used to cover emergencies.

## Why we carried out this inspection

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We did not have data relating to this practice because of the reporting system used by the practice. We carried out an announced visit on 16 June 2015. During our visit we spoke with a range of staff including the two senior partners, interim practice manager, and locum practice nurse and an administrative staff, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

# Are services safe?

## Our findings

### Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. 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. We reviewed records of seven significant events that had occurred during the last 12 months across the whole ICO Health Group and saw this system was followed appropriately. Significant events were a standing item on the organisation's meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the organisation 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 used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked all seven incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example a patient had made a complaint after reception staff had booked an ear syringing appointment at the wrong location. From this incident the organisation implemented a monthly update for reception staff on services offered at each location.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the organisation's GP clinical lead 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 clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed 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. All clinical staff had completed Level 3 child protection training. All administrative staff had completed Level 1 training. 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 ICO health group had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They worked across all the locations and offered support and guidance to other clinicians. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice'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. The practice had identified the risk that patients registered at the practice could be seen at any

## Are services safe?

of the other locations. Therefore they kept in depth electronic records and the flagging system helped staff to quickly identify all vulnerable patients and ensure they liaised with the lead professionals.

There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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. We were told by the practice that only clinical staff acted as chaperones. Due to the number of different practices available patients were advised to request for a chaperone at the time of booking an appointment and staff ensured that the appointment was scheduled at a location where a chaperone was available.

All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription

forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked ten anonymised patient records which confirmed that the procedure was being followed.

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

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in January 2015

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

The practice had established a service for patients to pick up their dispensed prescriptions at a number locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required. One of the senior partners who held the management role had been to meet with local pharmacies to discuss better ways of working and information sharing.

### Cleanliness and infection control

## Are services safe?

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use 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.

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 that 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 that the findings of the audits were discussed.

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 which can contaminate water systems in buildings). 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. The last check had been completed in May 2015

### 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, spirometers, blood pressure measuring devices and the refrigerator thermometer. We saw evidence that calibration of all relevant equipment had been completed in January 2015.

### Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. 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 the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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 met 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 regular 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 displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of

## Are services safe?

this, the practice and the other locations were planning to move into a new location in the next 12-18 months. As part of the move potential risks had been identified and the practice was working on ways to minimise them.

### **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 in cardiac emergencies). We checked that the pads for the automated external defibrillator were within their expiry date. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Emergency medicines were easily accessible to staff 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 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. 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. The plan was last reviewed in 2014

The practice had carried out a fire risk assessment in 2015 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.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their 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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

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

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. However we found that a number of patients with diabetes had not been offered regular health checks. The practice had invited these patients to attend the health reviews and the patients had failed to do so. However they were instances when these patients had attended the practice for other reasons and staff did not use these opportunistic contacts to carry out the checks.

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 review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure

multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy 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. All of these were completed full audits where the practice was able to demonstrate the changes resulting since the initial audit. The first audit had been conducted between November 2013 to November 2014. The purpose was to ensure that patients with diabetes being treated with insulin were educated about the risk of hypoglycaemia. (Hypoglycemia, also known as low blood sugar or low blood glucose, is when blood sugar decreases to below normal). During consultations the practice clinical staff spoke to diabetic patients to establish their understanding of hypoglycaemia and how to recognise the signs and symptoms. They found that 64% percent of patients had been given hypoglycaemia advice and were able to identify symptoms and the actions to take. As a result of the findings the practice changed their patient consultations to ensure that all clinical staff gave advice on hypoglycaemia during review of diabetics. Following a six month period the practice re-audited and found that 100% of the patients were fully aware of hypoglycaemia and how to recognise the signs and actions to take should they be affected.

# Are services effective?

## (for example, treatment is effective)

Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

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 to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 91.8% of the total QOF target in 2014, which was in line with the CCG average of 92%.

- Performance for diabetes related indicators was similar to the national average. We found that a small number of patients with diabetes had failed to attend annual health checks. However despite attending the practice for other reasons, they had not been offered opportunistic screening.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- Performance for mental health related and hypertension QOF indicators was similar to the national average.
- The dementia diagnosis rate was comparable to the national average.

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 followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence 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 practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as those with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions such as Heart failure.

The practice was involved with other local practices in reviewing their performance. This involved meeting with the medicines management team from a local cluster of practices. Referral data and prescribing data was discussed with improvement areas highlighted. This formed part of a peer review process.

### 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 annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, such as immunisation updates and safeguarding.

The practice nurse had a job description outlining their roles and responsibilities and provided evidence that they



# Are services effective?

## (for example, treatment is effective)

were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology. 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 patient's needs and manage those of patients with complex needs. 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 practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

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

### Information sharing

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

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence 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 with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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

# Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. 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 used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

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

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

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help.

The practice offered cervical screening to all their patients. The practice performance for cervical smear uptake was 74% for the 2013 /2014 period which was in line other practices in the CCG. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example: childhood immunisations was 86% and was in line with the CCG average.

# 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 25 completed cards and the majority 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 did not have practice specific data from the gp patient survey. However all eight patients we spoke with on the day of our inspection; told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. It was clear from all the patient feedback that the practice was performing well in this area.

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 / 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 located away from the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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**

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

Staff told us 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.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice were aware of the high number of asylum seekers in the area and so were flexible in registering patients and offered a wide range of health screening.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population.

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 population in the local area. This information was used to help focus services offered by the practice.

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 were available on the practice website. 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) such as the availability of Saturday appointments from one of the other practices.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and patients who required translation services. The majority of the practice population were English speaking patients but access to online and

telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs available in the practice; therefore patients could choose to see a male or female doctor at a specific location if required.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

### Access to the service

The surgery was open 8.00am-6.30pm Monday-Friday. Early morning surgeries are offered on Monday, Wednesday and Thursday from 7.00am and late night surgeries on Tuesday, Wednesdays and Thursdays from 6.30pm-8.30pm. The practice operated a routine pre-booked GP Saturday surgery from 9.00am-11.00am from of the other surgery. All late nights and Saturdays also had a practice nurse surgery running.

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

# Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed 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 was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice and this was the practice manager.

We saw that information was available to help patients understand the complaints system. This was included in

the practice information leaflet and displayed in the reception area. 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 five complaints received in the last 12 months. All complaints had been dealt with in a timely manner and had been resolved. Examples of complaints received included an incident where a patient had been booked for ear syringing at the wrong location due to an administrative error. We saw that the practice responded by sending an apology letter to the patient and internally concluded that the reception staff should be given a monthly update of the locations where treatments are to be booked for. We also noted all complaints had been discussed and shared with all staff at practice meetings.

The practice reviewed complaints on an annual basis to detect themes or trends. These were split into complaints relating to GPs, nursing staff, administration staff, reception and the general management of the practice. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and 5 year business plan. We saw evidence that the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients.

We spoke with four members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of the organisation's practice meetings and saw that staff had discussed and agreed that the vision and values were still current.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight policies and these had been reviewed annually and were up to date. There was a clear leadership structure with named members of staff in lead roles. For example, there was senior clinical lead for the organisation, who offered clinical support to all staff and was also took the lead in organisational management.

All staff were 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.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). 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 organisation meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example the risk vulnerable of patients being seen by different professionals. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

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

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

### Leadership, openness and transparency

The leadership structure of the practice was clear to all staff. All four staff we spoke with told us who the lead person was at the practice and the wider organisation. From our discussions with staff we found that the organisations senior management including clinical directors frequently visited the practice and were easily accessible to staff.



# Are services well-led?

Good 

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

Records showed that team meetings were held weekly and 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 or at any time with the practice manager or GPs.

The human resources manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as disciplinary procedures, induction policy and management of sickness which were in place to support staff. All policies were up to date. 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 an active patient participation group (PPG) which had steadily increased in size. Findings from PPG surveys and information on how to be involved with the PPG was shared with patients via a newsletter or on the practice website. The PPG contained representatives from various population groups; including the retired and some ethnic minority patients. The PPG had carried out yearly surveys and met every 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 were available on the practice website.

The practice had also gathered feedback from staff through staff away days and generally 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.

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four 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 with staff at meetings to ensure the practice improved outcomes for patients such as the complaints received from patients.