

# The Cabin 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 The Cabin Surgery on 7 September 2016. Overall the practice is rated as good.

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

- The leadership and approachability of the principal GP underpinned safe and caring clinical care for patients.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- The majority of risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- There was good continuity of care, with urgent appointments available the same day, though the wait to see a named GP could be longer.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw two areas of outstanding practice:

The principal GP conducted regular checks of patient consultations for all other clinicians. The GP regularly discussed areas for improvement with locums and employed clinical staff.

# Summary of findings

The practice was forward thinking in adapting to new guidance and best practice and created templates to support clinicians during consultations. Where appropriate, these were shared with other practices locally which improved patient care more widely.

The areas where the provider should make improvement are:

- Complete the action plan to introduce a legionella control regime as recommended by the water safety assessment.
- Conduct a risk assessment for substances stored in the boiler cupboard to demonstrate that potential risk to staff and patients is reduced.

- Consider the introduction of a formal complaints log to document complaints handling in line with the practice policy.
- Implement a system to check that cleaning has been carried out in line with the cleaning schedule.
- Review personnel management processes for recruitment and training to demonstrate records are consistently up to date for all employees, including GPs. The recruitment policy should be consistently applied to all new staff, including appropriate checks for all employees and clinicians prior to their commencement of employment. Complete the work to bring all annual staff appraisals into date.

**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.

Good



- There was an effective system in place for reporting, recording and reviewing significant events. This included events with positive outcomes which indicated a safety culture which valued positive shared learning to improve patient care.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Most risks to patients were assessed and well managed. Work was under way to implement a legionella control regime (legionella is a term for a particular bacterium which can contaminate water systems in buildings). The inspection observed that small quantities of flammable materials had been stored in the cleaning cupboard where the gas boiler and hot water tank were also located. The practice had been unaware of this and a risk assessment of these substances and their storage was required to improve patient safety.
- There was a comprehensive recruitment policy in place although the practice had not carried out checks on a clinician who was currently employed as a locum GP following a previous training placement with the practice. Checks were carried out on this member of staff during the inspection process and a DBS applied for the day following the inspection

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- The practice was aware of the needs of the patient population and worked with the Clinical Commissioning Group (CCG) to try and extend services to meet the needs where possible.
- There was a focus on effective individual learning and shared learning which contributed to effective patient care.

# Summary of findings

- Staff assessed needs and delivered care in line with current evidence based guidance, though we were unable to see up to date training records for an employed GP during the inspection.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff, although one member of staff had not had an appraisal for three years when we visited. This was undertaken the day following our visit.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

## Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example, 95% of patients said that last time they saw a GP, the GP was good at treating them with care and concern which was above the national and CCG average of 85%.
- Feedback from patients was positive with patients saying they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- One of the practice values was "support for our patients when they are going through difficulties in their lives" and patient feedback showed this was carried out.
- Information for patients about the services available was easy to understand and accessible.
- The practice had identified 98 patients as carers and 83 patients as having a carer. Figures showed that 50 carers were given a seasonal influenza vaccination in 2015/16 and the practice shared plans to raise awareness of support for carers with the inspection team.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Staff described occasions when they had required care and support. They said that this had been given sensitively, recognising their preferences, and that they felt cared for and appreciated.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice was aware of the needs of its local population and engaged with the NHS England Area Team and Clinical

# Summary of findings

Commissioning Group (CCG) to secure improvements to services where these were identified. This included providing a deep vein thrombosis (DVT) diagnostic testing service for patients and working with other practices to implement a GP community matron for housebound patients who were over 75 years old. The practice was also part of the local GP federation, East Lancashire Union of GPs which was working with the CCG to review and improve extended hours services for patients.

- Patients said there was good continuity of care, with urgent appointments available the same day, although they did have to wait for routine appointments if they wished to see a named GP.
- 95% of patients who responded to the GP survey said that the last appointment they got was convenient, which was above the CCG and national average of 91%.
- 84% of patients who responded to the GP survey said that the last time they wanted to see or speak to a GP or nurse they were able to get an appointment which was above the national average of 76%.
- Information about how to complain was available and easy to understand. The practice had not received any formal complaints in the last two years but reviewed feedback from NHS Choices and the practice website. Learning from complaints was shared with staff and other stakeholders.

## Are services well-led?

The practice is rated as good for being well-led.

- The principal GP provided active leadership and oversight of all areas of clinical practice and supported the practice manager with the non-clinical managerial responsibilities.
- There was a clear staffing structure with staff clearly aware of their own roles and responsibilities.
- The practice aims and objectives were to provide high quality medical care to the whole population. Staff were clear about the vision and their responsibilities in relation to it.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The principal GP encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients, which it acted on.

Good



# Summary of findings

- The practice was committed to developing trainee GPs and encouraging all staff to undertake relevant training and development. Reflective learning was encouraged and shared.
- The practice held weekly clinical meetings and regular multi-disciplinary meetings with other health and social care providers to ensure safe and continuous shared care.
- The administration of meetings was notably straightforward and effective.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people.

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population. This included a GP community nurse who provided care for all housebound patients who were over 75.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The GP community matron had worked with colleagues and a range of health providers during November and December 2015 to collect gifts which were donated to older people in the local area. Over 2,000 patients, some of whom were housebound and in residential settings received gifts as part of this scheme.

### People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice nurses were able to commence newly diagnosed diabetic patients on injectable insulin therapy if appropriate, which reduced the need for these patients to attend secondary care for enhanced diabetes support and management.
- 100% of patients with atrial fibrillation (AF, a heart condition) whose risk of stroke was clinically assessed as high were treated with appropriate medication which was above the CCG and national averages of 98%.
- All five indicators for diabetes were above or in line with local and national averages. For example, 87% of patients with diabetes had a recent blood sugar test which was within a normal range, which was above the CCG average of 79% and national average of 78%.
- Practice data for 2015/16 showed that 77% of patients with asthma and 96% of patients with chronic obstructive pulmonary disease (COPD, a lung condition) had attended a review in the previous 12 months.
- Longer appointments and home visits were available when needed.



# Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients 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

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- 85% of eligible women had attended cervical screening which was above the CCG and national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- Family planning and contraception advice and prescribing was available and the practice referred patients who required long lasting reversible contraception to local clinics.

Good



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

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered 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.
- Telephone appointments were available for patients who were unable to attend the practice during normal working hours.
- The practice provided minor surgery for excisions and injections for joint pain.

Good



# Summary of findings

## People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability and conducted an audit to ensure that relevant information on patients with learning disabilities who were referred to secondary care was shared to ensure that appropriate adaptations to services and appointments could be made to meet the needs of each individual patient.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed 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)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good



- In 2014/15 71% of patients with dementia had their care reviewed during a face-to-face meeting in the last 12 months, which was below the CCG average of 82% and the national average of 84%. Practice data for 2015/16 showed this had increased to 84% although this had not been nationally validated at the time of our visit.
- 93% of patients with severe mental health conditions had their care reviewed in the previous 12 months, which was above the CCG and national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice 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.

# Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016 based on results from surveys issued between January and March 2016. The results showed the practice was performing highly compared with local and national averages. The practice regularly reviewed the GP survey data to review areas for improvement. Responses were collated from 108 survey forms, from the 248 which were distributed (a 44% response rate). This represented 2% of the practice's patient list.

- 86% of patients found it easy to get through to this practice by phone compared to the Clinical Commissioning Group average of 72% and the national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 94% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 32 comment cards all of which were highly positive about the surgery and the care they were given by staff and GPs. Patients said that the care they received was excellent and that the practice was extremely efficient and conscious of patients' needs and anxieties. Patients praised individual clinicians for the care and support they gave.

We spoke with three patients during the inspection, one of whom was also a member of the patient participation group (PPG). All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. We were told that there was sometimes a wait for appointments, and that confidentiality was difficult in the waiting area.

Friends and family (FFT) test data for the practice showed that patients were positive about the practice. Data provided showed that 73 patients had completed FFT responses since April 2016. In April 12 patients completed returns of whom 11 said they would be extremely likely or likely to recommend the practice, 92%. Between May and August 2016 all patients said they would be likely or extremely likely to recommend the practice, 100% each month. The overall total for the five month period was 99% of patients who would recommend the practice.

## Areas for improvement

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

The areas where the provider should make improvement are:

- Complete the action plan to introduce a legionella control regime as recommended by the water safety assessment.
- Conduct a risk assessment for substances stored in the boiler cupboard to demonstrate that potential risk to staff and patients is reduced.
- Consider the introduction of a formal complaints log to document complaints handling in line with the practice policy.

- Implement a system to check that cleaning has been carried out in line with the cleaning schedule.
- Review personnel management processes for recruitment and training to demonstrate records are consistently up to date for all employees, including GPs. The recruitment policy should be consistently applied to all new staff, including appropriate checks for all employees and clinicians prior to their commencement of employment. Complete the work to bring all annual staff appraisals into date.

# Summary of findings

## Outstanding practice

We saw two areas of outstanding practice:

The principal GP conducted regular checks of patient consultations for all other clinicians. The GP regularly discussed areas for improvement with locums and employed clinical staff.

The practice was forward thinking in adapting to new guidance and best practice and created templates to support clinicians during consultations. Where appropriate, these were shared with other practices locally which improved patient care more widely.

# The Cabin Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist adviser and a second CQC inspector.

## Background to The Cabin Surgery

The Cabin Surgery provides primary medical care to around 4,521 patients within the small rural town of Rishton in East Lancashire under a general medical services (GMS) contract with NHS England. The practice is part of the East Lancashire Clinical Commissioning Group (CCG). The practice is located on Rishton High Street, Blackburn.

The practice building is owned by the principal GP and maintained by the practice. It is adjacent to Rishton community clinic, although this building closed recently and services moved elsewhere. The building is a single storey purpose built practice which has been adapted to accommodate increased services and staff.

The practice clinical team comprises a male GP sole provider and one salaried female GP and one female locum GP, as well as two female nurses and a GP community nurse who provides care for housebound patients aged over 75 for four local practices. A practice manager and team of seven reception and administrative staff support the clinical team. The practice is a GP training practice and was supporting one trainee GP at the time of our visit.

The patient population differs slightly from average practice populations, with more patients aged 50 and over and fewer patients aged 25 to 44 years old than average.

Male and female life expectancy is just below national averages (male: practice 77 years, England 79; female: practice 82 years, England 83).

Information published by Public Health England rates the level of deprivation within the practice population as four on a scale of one to 10 (level one represents the highest levels of deprivation and level 10 the lowest). East Lancashire has a higher prevalence of Chronic Obstructive Pulmonary Disease (COPD, a disease of the lungs), smoking and smoking related ill-health, cancer, mental health and dementia than national averages.

When the practice is closed out of hours services are provided by the ELMS out of hours service which patients contact by ringing NHS 111.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 September 2016.

# Detailed findings

During our visit we spoke with a range of staff including three GPs and the GP trainee, one practice nurse and the GP community matron, the practice manager, practice administrator and reception staff. We also spoke with patients who used the service and one member of the patient participation group. In addition we:

- Observed how staff interacted with patients and talked with carers and family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service and friends and family test (FFT) results provided by the practice.

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 were provided for specific groups of people and what good care looked 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).

Please note that when referring to information throughout this report, for example Quality and Outcomes Framework (QOF) data relating to 2014/15 is validated national data and data relating to 2015/16 is data provided by the practice during inspection which has not been validated. Local and national averages have not been applied to 2015/16 data.

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form did not support the recording of notifiable incidents under the duty of candour but the practice was aware of the requirement to report incidents. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of significant events and these were reviewed appropriately to ensure that learning and actions had been completed.
- The practice had identified two positive significant events which were shared with the team. This supported a positive learning culture within the practice.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. An example was when a refrigerator door had accidentally been left open, which affected vaccine storage. The practice discussed and shared the concerns and ensured that all staff were aware of how to support the safekeeping of vaccines to protect patient safety in future.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse. Arrangements which reflected relevant legislation and local requirements were in place to safeguard children and vulnerable adults. Policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. The principal GP was the safeguarding lead. The GPs and nurses met regularly

with health visitors and attended meetings where required or provided reports for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. We were informed that GPs were trained to child protection or child safeguarding level 3, though unable to see confirmation for the salaried GP of training dates. Nurses were trained to safeguarding level 2.

A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. There was a contract with a cleaning company and a schedule in place, although records were not kept to confirm areas had been cleaned in line with the schedule.

There was an effective stock control system and arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines, although these were not fully documented in a local protocol. The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The GP community nurse was an independent non-medical prescriber and was supported with this by the principal GP where appropriate.



## Are services safe?

The practice had a very low turnover of staff and the latest member of staff had been recruited three years ago. The practice had a comprehensive policy in place to ensure that relevant checks were undertaken during the recruitment process, although these checks had not historically been applied to all staff. The recruitment policy indicated that checks included proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. One locum GP had completed training with the practice and the practice had not followed up with checks when they began to employ them as a locum GP, although they rectified this during the inspection and a DBS application was submitted.

### Monitoring risks to patients

Risks to patients were generally assessed and well managed though we noted one or two areas which required closer attention by the practice in future.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had commissioned a water safety report in July 2016, which recommended various actions to implement a legionella control regime. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice was still reviewing the actions required to reduce potential risk of legionella in the water system. The practice contracted a cleaning service which provided the cleaning chemicals which were stored in a cupboard with the boiler and water tank. Although two cleaning substances had control of substances hazardous to health and infection control (COSHH assessments), other products did not, and there were three flammable, pressurised containers

stored in this room without risk assessment. We also noted that the cupboard was used to store part used paints, one of which was a flammable substance. The practice manager was not aware these items were stored in the cupboard and removed these immediately. We discussed the need for the practice to ensure that products and this area were more carefully monitored and risk assessed to prevent potential risk to patients and staff in future.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Clinical staff were supported in maintaining their own preferred appointment balance and allocated time for administrative tasks. Administrative staff worked part time and supported each other with leave and sickness cover where required.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Staff received basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. First aid equipment was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The practice manager held all staff contact numbers and the plan could be accessed from outside the practice through the IT system.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Practice nurses reviewed relevant updates to NICE guidelines where appropriate, and summarised these to support GPs. An example which we observed was a revised template for asthma medication which the nurses had shared with GPs at a clinical meeting to support their prescribing.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The principal GP acted as trainer to GP trainees, and reviewed consultation notes to support the learning and development of trainees. He also applied this to employed GPs, and supported them with positive feedback about consultations and updated guidelines.

### 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 system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.5% of the total number of points available. The practice had a 10% clinical exception rate (clinical exception is carried out where a patient might not be suitable for a specific treatment or assessment).

This practice was not an outlier for any QOF (or other national) clinical targets.

- Performance for diabetes related indicators was in line with or better than the national average.
- 82% of patients with diabetes had a recent blood pressure reading which was within a normal range, which was above the national average of 78%. Also, 82% of patients with diabetes had a record of a foot

examination in the previous 12 months which was below the national average of 88%. Practice data for 2015/16 showed achievement for both indicators was 93%.

- Performance for mental health related indicators was better than the national average with 93% of patients with severe mental health conditions having had a review in the previous 12 months compared to the national average of 88%.
- The practice had identified 32 patients as having dementia. Of these patients, 71% had a care review undertaken in the previous 12 months, which was below the national average of 84% and Clinical Commissioning Group (CCG) average of 82% (2014/15 data). Practice figures for 2015/16 showed this had increased to 84%.

Quality improvement and assurance was embedded into all aspects of the practice. The principal GP reviewed patient records and details of consultations for all clinicians and supported the development of all staff with constructive feedback and areas for improvement. Staff were supported to develop local templates within the IT system to ensure care for patients was consistently in line with best practice and new guidance. Clinical staff and GP trainees appreciated the level of detail and attention which was given in this respect.

A range of clinical audits had been completed in the last two years; three of these were completed audits where the improvements made were implemented and monitored. The information from audits was used to ensure that patient outcomes were continuously improved. Audits areas and improvements for patients included:

- Valproate (medication used to treat epilepsy and some migraine or personality disorders) and giving contraception advice: the practice increased the number of patients prescribed these medicines who were aware of the risks should they conceive whilst taking this medicine.
- Cervical cytology: the practice continually reviewed data from the cervical screening process to reduce the inadequate smear rate and ensure patients with abnormal results or inadequate results were recalled.
- Secondary prevention of osteoporosis: the audit reviewed patients with fragility fractures to ensure they were prescribed appropriate medication.
- A single cycle audit on new oral anticoagulant drugs (NOAC) had been carried out and a template designed

# Are services effective?

## (for example, treatment is effective)

in the IT system which had been shared with other practices in East Lancashire to support GPs prescribing these medicines. The practice had scheduled the audit for review in 2017.

- Care for patients with learning disabilities: the practice reviewed whether patients had attended relevant national screening programmes and also reviewed referrals to secondary care to ensure that referrals included information which would ensure that these patients were given adequate time and support when attending other health care services.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. This included the CCG medicines management reviews, to ensure that prescribing was in line with national guidance and reduce the incidence of inappropriate medications. The CCG medicines management pharmacist shared evidence with us to demonstrate that the practice made consistent improvements in prescribing and reviewing patients' medication to ensure prescribing was in line with best practice and local guidance.
- The practice also participated in a local incentive scheme to carry out diagnostic testing for patients with suspected deep vein thromboses. This improved outcomes for patients by offering the service closer to home and reduced the impact on secondary care where the patient met the criteria to be treated in the community. Six patients had been assessed under the scheme in 2015/16 and four to date in 2016/17.
- The practice nurses were trained to support patients with a range of long-term conditions and were trained to initiate insulin therapy for newly diagnosed diabetics. This offered a service closer to home for these patients and allowed for greater continuity of care.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- Although the practice had not recruited staff in the last three years, they had a comprehensive induction programme in place for GP registrars which ensured that they began their placement knowing a great deal of essential information. The practice could also describe

the induction programme that had been used for newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Nurses attended regular training for respiratory and diabetes care.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence, although we were unable to see evidence that one GP had attended refresher training for cervical screening. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. We were unable to view training records for a salaried GP although assured training had been completed. We noted that one member of staff had not received an appraisal since 2013. This was completed immediately following the inspection. Other staff had received an appraisal in 2015, and there was a plan in place for these in 2016.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- As a training practice, the practice was committed to supporting and developing clinicians for the future and had a positive approach to staff training and development. Non-clinical staff were supported to undertake additional training such as certification from the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists and practice nurses were supported and encouraged to attend a wide range of training and development.

### Coordinating patient care and information sharing

# Are services effective?

## (for example, treatment is effective)

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Practice staff worked closely with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals every two months when care plans were routinely reviewed and updated for patients with complex needs.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support, and offered additional support and signposting to relevant services such as counselling and smoking cessation clinics. Specific patient groups identified included:

- Patients receiving end of life care,
- Carers
- Patients at risk of developing a long-term condition
- Patients at risk of hospital admission and those discharged from hospital
- Patients requiring advice on their diet, smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 85%, which was higher than the CCG and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different formats (for example for patients with a learning disability) and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening, and National Cancer Information Network data published in March 2015 showed attendance at screening was in line with national and CCG averages.

Childhood immunisation rates for the vaccinations given were higher than national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 63% to 90%, compared with national averages of 71% to 86% and five year olds from 82% to 98%, compared with national figures of 68% to 97%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. One of the practice values was to support patients when they were going through difficulties in their lives and it was evident that patients felt cared for from the comment cards we received during the inspection.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 22 patient Care Quality Commission comment cards we received were positive about the service experienced. The cards highlighted that patients believed that the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

We spoke with three patients, one of whom was a member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They gave us examples of how the practice responded positively to suggestions for improvement. We were also advised that the reception area and patient waiting area did at times impact on confidentiality. The practice had installed glass screens on reception to try to address this, and could offer a private room where requested by a patient.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.

98% of patients said the GP gave them enough time compared to the CCG and national average of 87%.

- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 96% of patients said the last GP they spoke to was good at treating them with care and concern compared to CCG and national averages of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

### Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results 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. Results were above local and national averages. For example:

- 97% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and the national average of 86%.
- 94% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 93% and the national average of 82%.
- 95% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

## Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. The practice used a sign language interpreter service for a patient when required.
- Information leaflets were available in easy read format.

The practice policy where medication changes were required was to ensure that patients were seen and the reasons for considering a change were discussed and recorded in consultation notes. This reduced the incidence of patient queries over changes and contributed to the ongoing continuity of care for patients.

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

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 98 patients as carers (2% of the practice list). Of these, 51% had received a seasonal influenza vaccination during the previous "flu" season, and 31% had been offered a health check. The practice had plans in place to identify more carers and increase the support given during 2016/17. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that following bereavement, the practice manager contacted the next of kin and supported them with advice and guidance and empathy. Patient comments said that the practice care for palliative patients was excellent and appreciated. Written information on support services was also available if required.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice was aware of the practice demographics and 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. For example, the practice had worked with other local practices to provide a GP community nurse for housebound patients who were aged over 75 years and the practice offered a local service under a contract with the CCG to conduct diagnostic testing for deep vein thromboses.

- The practice had adapted GP surgery times to offer some 6pm appointments to patients who worked, and the GP was flexible in arranging appointments if patients were unable to attend routine surgeries.
- The practice offered longer appointments for patients with complex medical conditions, mental health problems and learning disabilities.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Patients and children who requested an urgent appointment were seen or spoken to on the same day.
- The practice offered telephone appointments for patients who were unable to access the surgery during normal working hours.
- Nursing staff were trained to offer travel vaccinations but had recently suspended this service due to demand for appointments and patients were signposted to other local services.
- There were disabled facilities available but no hearing loop – the practice had a plan to obtain a hearing loop.
- The practice had considered whether it was possible to install a handrail outside the building for frail people walking from the car park and was taking health and safety issues into consideration to see how this could be facilitated.
- The practice had offered the health visiting team accommodation in the building following the re-location of the community clinic services from the adjacent clinic building.
- The practice had requested that the smoking cessation service offered clinics from the practice which had increased the access for many local people.

- GPs regularly visited patients who were living in care homes locally.
- Staff informed us of occasions when they had been unable to contact a patient by telephone or when important information needed communicating, when letters were often hand delivered on the same day to ensure patients received information in a timely way.

### Access to the service

The practice was open between 8am and 6:30pm Monday to Friday. Appointments were from 9 to 11 every morning and 3:30 to 5:30 daily. Later appointments until 6pm were available two evenings per week. Pre-bookable routine appointments were available. To see any clinician for a routine appointment the wait was around a week and for a named GP it could be three weeks. People told us on the day of the inspection that they were able to get appointments when they needed them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages.

- 84% of patients were satisfied with the practice's opening hours compared to the national average of 79%.
- 86% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

Reception staff worked closely with GPs when patients requested home visits and had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

### Listening and learning from concerns and complaints

The practice had an effective 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.
- The practice manager was the designated responsible person who handled all complaints in the practice.

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

- We saw that information was available to help patients understand the complaints system through information in the waiting area, in the practice leaflet and on the practice website.
- The practice reviewed feedback from NHS Choices and the practice website and responded to complaints or issues raised in this way.

The practice informed the inspection that they had received no complaints in the last two years so the inspection was not able to review complaints handling

procedures in detail. However, the practice described the process they followed and could explain occasions when apologies and explanations had been given to patients where issues had occurred. It was evident that all staff dealt with concerns and shared feedback from patients which reduced the necessity for formal complaints. For example, a patient had suggested to one GP that chairs with arms might be helpful. This was acted upon to ensure that patients who found it difficult to sit and stand when visiting the practice were more comfortably supported.



# 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 values were to provide top quality medical care for patients, to support patients when they were going through difficulties in their lives and help the future GP workforce by being a training practice. These values were integral to the whole practice. The practice was committed to continuous improvement and had action plans in place for ongoing improvements to the building and facilities for patients.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- The principal GP provided active leadership and oversight of all areas of clinical practice and supported the practice manager with the non-clinical managerial responsibilities. There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- The practice had arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions.
- The meeting schedule and organisation of meeting topics and agendas was well organised and effective. We saw evidence that a significant event which occurred in 2015 was listed for review at the meeting in November 2016, and meeting minutes evidenced that patient safety and shared learning was thorough and consistent.
- The practice valued effective communication. Weekly clinical meetings were usually attended by all clinical staff and relevant administrative staff. All staff were aware that they were invited to attend. Handover books

were in place in reception and for all clinicians, as well as the use of the internal messaging system. We observed a daily handover between reception staff when a staff changeover was taking place.

- Staff were allocated time to undertake additional duties and their level of commitment to good care and continuous improvement reflected a mutually supportive approach.

### Leadership and culture

On the day of inspection the principal GP demonstrated he had the experience, capacity and capability to run the practice and ensure high quality care. The evidence demonstrated that the practice prioritised safe, high quality and compassionate care. Staff told us the GP and practice manager were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The principal GP encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff were actively empowered to ensure that they had time to provide effective care and supported with clinical administration time. Nursing staff arranged their own appointment system to ensure that appointment lengths were adequate for each treatment. The salaried GP had arranged longer appointments which reduced waiting times in the practice for her patients.
- Staff said they felt respected, valued and supported, particularly by the principal GP and practice manager.

# Are services well-led?

Good 

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

All staff were involved in discussions about how to run and develop the practice and were encouraged to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had around 40 patients on the virtual patient participation group and sent email updates and information to these patients. The practice had gathered feedback through surveys and verbal comments or complaints received. The last survey had only four responses which the practice was disappointed with. The practice also reviewed national GP survey results and regularly reviewed and published Friends and Family Test (FFT) data to recognise good work and review where improvements could be made.
- Despite low formal complaints, the practice reviewed comments on the NHS Choices website and those submitted via the practice website, and shared these with all staff to ensure continue shared learning and development.
- Staff were actively encouraged to contribute to the development of the practice and told us they enjoyed a good working environment and recognised they offered their patients excellent service. Practice nurses shared examples of how they had suggested improvements to procedures, for example in dealing with patient urine samples handed in. This change was introduced and used by reception to ensure urine samples were handled and processed correctly.

## Continuous improvement

The practice had applied for and been awarded the Royal College of General Practitioners Practice Accreditation Award in 2014.

The practice was committed to continuous learning and development for all staff, with the principal GP acting as a GP trainer. They had a plan to develop this when a new salaried GP took up post in the future. The principal GP reviewed consultation notes in patient medical records routinely and helped trainee GPs and all clinicians develop their reflective learning approach to their work.

Reflective learning and development was embedded into practice culture. There were weekly clinical meetings and a planned schedule of multi-disciplinary working and training to ensure all clinicians were up to date and involved in all areas of patient safety and delivering quality patient care.

Practice nurses were empowered and supported to review clinical developments particularly in the management of long-term conditions which they led on. They shared with the inspection team revised templates they had made and summaries of updated guidance in the prescribing of inhalers for asthma which were given to GPs to support their prescribing practice.

The practice team was forward thinking and part of local incentive schemes to improve outcomes for patients in the area, this included the recruitment of the GP community nurse, the deep vein thrombosis assessment service, minor surgery and joint injections.

The practice was forward thinking in adapting to new guidance and best practice and created templates to support clinicians during consultations. Where appropriate, these were shared with other practices locally which improved patient care more widely.