

# Drs Perera, Harvey & Sandhu

## Quality Report

Halesowen Road  
Netherton  
Dudley  
DY2 9PU

Tel: 01384884030

Website: [www.nethertonhealthcentre.nhs.uk](http://www.nethertonhealthcentre.nhs.uk)

Date of inspection visit: 13 January 2015

Date of publication: 11/06/2015

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

### Ratings

#### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

### Detailed findings from this inspection

Our inspection team	10
Background to Drs Perera, Harvey & Sandhu	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

## Overall summary

### Letter from the Chief Inspector of General Practice

We completed a comprehensive inspection at Dr Perera, Harvey and Sandhu Medical Practice on 13 January 2015. We found the practice to be good in the five key areas that we looked at and gave the practice an overall rating of good.

Our key findings were as follows:

- Systems were in place to ensure that all staff had access to relevant national patient safety alerts. Staff signed to confirm that they had read these documents and they were discussed at clinical staff meetings.
- Infection prevention and control systems were well managed and staff had received appropriate training. Lead roles had been assigned to manage infection control and staff were aware of who held the lead role.
- Staff were friendly, caring and respected patient confidentiality. Patients we spoke with said that all staff were compassionate, listened to what they had to

say and treated them with respect. We observed that staff at the reception desk maintained confidentiality and appeared to have a good relationship with patients using the service.

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was evident when speaking with staff and patients during our inspection. There was a clear leadership structure with named staff in lead roles. Staff were aware who they should speak with if they needed guidance or advice. Staff reported that they worked well as a team and could approach the practice manager or GPs if they needed to discuss anything.

However, there were areas of practice where the provider should make improvements.

- Develop the Incident/significant event reporting, recording and monitoring process to ensure trends and lessons learnt are captured and shared internally, and where appropriate externally.
- Review process for recording details of children with a protection plan to ensure records remain updated.

# Summary of findings

- Develop robust medicine management systems to include records to demonstrate that medication to be used in an emergency is available and within its expiry date, systems to demonstrate that stock checks and stock rotation of vaccinations received at the practice take place and to develop systems for the management and monitoring of prescription pads.
- Ensure that records are available to demonstrate that equipment to be used in an emergency situation is regularly checked and maintained.
- Ensure that recruitment processes are followed so that information required under current legislation is obtained prior to employment.

**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 a safe service. Staff had received training regarding the safeguarding of vulnerable adults and children and clinical staff had undertaken Mental Capacity Act training. Practice nurses had undertaken infection control audits and action had been taken to address some issues identified. Infection prevention and control training had been undertaken. Staff understood their responsibilities to raise concerns, and report incidents and near misses. However, when things went wrong, reviews and investigations were not sufficiently thorough and lessons learnt were not communicated widely enough to support improvement. Robust recruitment checks had not been undertaken on the member of staff most recently employed. There was no documentary evidence to demonstrate that emergency equipment and medication was checked regularly to ensure that it was available and safe for use.

Good



### Are services effective?

The practice is rated as good for providing effective services. NICE guidance was referenced and used routinely. Effective arrangements were in place to identify, review and monitor patients with long term conditions and those in high risk groups. Patients had access to a range of support to maintain a healthy lifestyle and improve their health. The majority of staff have received core and mandatory training appropriate to their roles and further training needs had been identified and planned. There was evidence of staff appraisals to support their roles and personal development plans were in place for staff. Multidisciplinary working was evidenced.

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 care and treatment decisions. There were arrangements in place to provide patients with end of life care that was compassionate and respected patients' needs and wishes. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



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

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported recent

Good



# Summary of findings

improvement regarding access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had an active patient participation group (PPG) which worked together with practice staff to make changes to improve services and gather patient opinion regarding the service offered. The PPG is a way in which patients and GP practices can work together to improve the quality of the service. The practice had good facilities and was well equipped to treat patients and meet their needs.

## Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. All patients over 75 years of age had an allocated named GP. This is an accountable GP to ensure these patients received co-ordinated care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The wishes of people requiring end of life care were met, this included care being provided in the patient's home by the GP and multi-disciplinary team. Telephone consultations were available so patients could call and speak with a GP if they did not wish to or were unable to attend the practice.

Good



### People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Specialist clinics, screening and advice was offered to patients with long term conditions. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. All patients on the long-term condition registers received healthcare reviews and person-centered care plans had been developed. When needed longer appointments and home visits were available. The practice had a system in place to make sure no patient missed their regular reviews for long term conditions. The practice nurses had received the training they needed to provide good outcomes for patients with long-term conditions. Patients who were on long term medication as a result of their condition received regular reviews to assess their progress and ensure their medications remained relevant to their health needs.

Good



### Families, children and young people

The practice is rated as good for the population group of families, children and young people. Safeguarding procedures were in place for identifying and responding to concerns about children who were at risk of harm. Staff had undertaken training on child protection and were aware of their roles and responsibilities in relation to this. Systems were in place for identifying and following-up children who were at risk. For example, there was an alert system on the patients' electronic record although some of these records were not up to date.

Good



# Summary of findings

Immunisation rates were high for all standard childhood immunisations. The practice was proactive in monitoring and recalling children for scheduled immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with health visitors. Women were given advice and information about cervical screening programs.

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

The practice is rated as good for the population group of working age people (including those recently retired and students). The practice patient age profile is mainly those of working age, students and the recently retired. Recent changes introduced such as on-line booking, repeat prescription ordering and the addition of extra appointments to help staff manage capacity had helped to ensure that services reflected the needs of this population group. Patients were also able to order repeat prescriptions via email or in person at the practice. Extended opening hours for appointments were available on a Tuesday morning and patients who were unable to attend the surgery were able to speak with a GP over the telephone who would give advice or arrange an appointment as necessary. NHS health checks for people aged between 40 and 74 years of age were undertaken as well as a range of health promotion and screening services which reflected the needs for this age group. Lifestyle advice was offered such as advice on smoking cessation. Women were given advice and information about cervical screening programs. However, the practice's performance for cervical screening was 2% lower than the average in the area. The practice were aware that they were lower than local averages regarding the blood pressure monitoring of patients with hypertension and had taken some action to try and address this issue.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients and had sign posted vulnerable patients to various support groups and third sector 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 and out of hours. The practice offered longer appointments for people with learning disabilities.

Good



# Summary of findings

Patients had access to an interpreting service if English was not their first language so that they could have a consultation with the GP in a language they understood.

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

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. A mental health link worker visited the practice twice per month and patients could then be referred to the Early Access Service (EAS) to enable GPs to access services in Secondary Care.

Clinical staff were aware of the Mental Capacity Act and were able to describe how they implemented it in their practice. These staff had undertaken Mental Capacity Training.

The practice had been identified as worse than average and at an elevated risk regarding some QOF targets, for example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months and the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months. The practice were aware of these issues and had plans in place to address but at the time of inspection had not started working on these identified risks. QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

Good





# Summary of findings

## What people who use the service say

As part of the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received three completed comment cards and on the day of our inspection we spoke with nine patients. Patients gave positive feedback about the service received and we were told that staff were caring and attentive. We were told that GPs listened and were understanding of patient's needs.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. During 2014 eight patients had left comments about this practice, six of these patients had left negative feedback and two positive.

We looked at results of the national GP patient survey carried out in 2012/13. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. In some areas the practice performed below the CCG average:

- The proportion of patients who would recommend their GP surgery was 59% (local CCG average 76%)

- 70% of respondents said the last GP they saw or spoke to was good at giving them enough time (local CCG average: 87%)
- The proportion of respondents to the GP patient survey who described the overall experience of the GP surgery as good or very good was 69% (local CCG average 84%).

In other areas the practice performed better than the CCG average:

- 76% of respondents usually waited 15 minutes or less after their appointment time to be seen (local CCG average 65%)
- 94% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care (local CCG average 86%)
- 98% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern (local CCG average 90%)

These results were based on 118 surveys that were returned from a total of 347 sent out; a response rate of 34%.

## Areas for improvement

### Action the service SHOULD take to improve

- Develop the Incident/significant event reporting, recording and monitoring process to ensure trends and lessons learnt are captured and shared internally, and where appropriate externally.
- Review process for recording details of children with a protection plan to ensure records remain updated.
- Develop robust medicine management systems to include records to demonstrate that medication to be used in an emergency is available and within its expiry

- date, systems to demonstrate that stock checks and stock rotation of vaccinations received at the practice take place and to develop systems for the management and monitoring of prescription pads.
- Ensure that records are available to demonstrate that equipment to be used in an emergency situation is regularly checked and maintained.
- Ensure that recruitment processes are followed so that information required under current legislation is obtained prior to employment.

# Drs Perera, Harvey & Sandhu

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC lead inspector; the team included a second CQC inspector, a GP and a practice nurse.

### Background to Drs Perera, Harvey & Sandhu

Drs Perera, Harvey and Sandhu are based in Netherton in the Dudley Clinical Commissioning Group (CCG). The practice provides primary medical services to approximately 7,300 patients in the local community. The practice is based in a health centre with members of the multi-disciplinary team on site, for example district nurses, physiotherapist and midwife. The population covered is predominantly white British with high levels of unemployment.

The lead GP at the practice is male and was present during our inspection. There are also another two male GP partners in this practice. A female GP worked at the practice for six sessions per week. This helped to ensure that patients could book an appointment with a female GP if they preferred. A locum GP also works regularly at the practice. Dr Harvey no longer works at this practice but remains on the CQC register and therefore their name is included in this inspection report. There are two female practice nurses, three full time and four part time administration staff and a full time practice manager.

The practice offered a range of clinics and services including, asthma, child health and development, COPD and minor surgery.

The practice opening times are from 8am until 6.30pm Monday, Wednesday, Thursday and Friday and extended opening hours were provided on a Tuesday from 7am until 6.30pm. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hours service contracted by the CCG.

We previously inspected Drs Perera, Harvey and Sandhu on 17 October 2013. At the time we found that the provider did not have suitable arrangements in place to ensure that staff received appropriate training and support. We also found that the provider failed to identify and manage risks to patients or to monitor the standards of care they received. We inspected this practice again in June 2014 to monitor progress with issues identified. We found that some issues had not been addressed relating to managing and monitoring risks to patients or standards of care they received. We reviewed these areas during this inspection to monitor whether the practice was meeting fundamental standards.

### Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We previously inspected this medical practice on 4 June 2014 and found that improvements were required. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

# Detailed findings

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

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We carried out an announced visit on 13 January 2015. During our visit we spoke with a range of staff including GPs, nurses, practice manager and administration staff and we spoke with patients who used the service. We also spent some time observing how staff interacted with patients. We spoke with members of the Patient Participation Group (PPG) who told us their experience not only as a member of the PPG but also as a patient of the service. The PPG is a way in which patients and the practice can work together to improve the service.

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

# Are services safe?

## Our findings

### Safe Track Record

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

We reviewed safety records and incident reports and minutes of meetings where these were discussed. We could not find evidence to demonstrate that complaints and incidents had been discussed at full staff meetings but we saw that they were discussed at clinical staff meetings. A member of clinical staff we spoke with gave an example of a recent significant event which had resulted in a medication error and discussed the action taken to address the issue.

There was no system in place for an annual review of complaints. We saw that individual complaints were discussed at clinical staff meetings but we were told by the practice manager that there was no overall analysis of complaints to identify trends.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. However, the system in place to ensure staff learnt from these incidents was not robust. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Administration staff that we spoke with discussed the systems for logging incidents/significant events which involved recording information on an online report template. We looked at two significant event forms. One form recorded details of the significant event, investigation and action taken. We were told that this was discussed at a clinical staff meeting held in December 2014 and we saw the minutes of this meeting to confirm this. The second significant event related to a prescription error. The records seen provided very little detail, the recorded action taken was minimal and there was no outcome or evidence of lessons learnt.

Clinical staff spoken with confirmed that significant events, incidents and complaints were discussed at their regular

weekly clinical staff meeting and they were able to give some examples. A member of administration staff told us that they were also discussed at full practice meetings if relevant. Full staff meetings were held on a less regular basis but we were told that monthly meetings had been arranged throughout 2015.

We saw the significant event policy. The policy had not been signed to demonstrate that it had been recently reviewed. The policy gave staff brief information on the definition of a significant event and how to report and log the information. The policy did not contain any information for staff telling them the processes involved in managing, investigating or sharing information regarding significant events.

National patient safety alerts were disseminated by the practice manager to relevant staff to read and sign off. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for, for example a recent alert regarding Ebola and another regarding a locum GP who was applying for work but who was not on the performers list. We saw that staff had signed records to demonstrate that they had read safety alerts. Safety alerts were discussed at clinical staff meetings to ensure all were aware of any relevant to the practice and where action needed to be taken. All staff spoken with knew where patient safety alerts were kept.

### Reliable safety systems and processes including safeguarding

The practice had a GP appointed as the lead in safeguarding vulnerable adults and children who had been trained to an appropriate level in safeguarding to enable them to fulfil this role. All staff we spoke with were aware who this lead was and who to speak to in the practice if they had a safeguarding concern. We saw that there was a policy regarding the protection of vulnerable children and work had commenced on developing a policy regarding vulnerable adults.

Practice training records made available to us showed that the majority of staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff confirmed the level of training they had completed.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding

## Are services safe?

concerns and were aware that they should contact the relevant agencies in and out of hours. Contact details were not easily accessible to staff and one member of staff we spoke with had difficulty in finding the information required.

One of the GPs spoken with was not aware whether copies of any minutes of child or adult protection meetings were sent to the practice. The practice manager told us that the minutes of these meetings were received and were scanned onto the relevant patient's records. An alert was then included on their file and the parent's file. We were told that safeguarding information was not discussed at practice meetings. The practice manager told us that there had been no issues that required including in these meetings.

Staff showed us the system in place to highlight some vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children with protection plans. We saw that alerts had not been put on the system to identify the parents of children with a protection plan. Computer records identified 78 patients at the practice with a child protection plan. We saw that some of these children were over 19 years of age and therefore the alert on the patient's record should have been removed. We found that there were no systems in place to ensure that patient records were complete and up to date.

A chaperone policy was in place and had been reviewed on a regular basis. Signs notifying patients of the availability of chaperones were visible on the waiting room and on consulting room doors. Chaperone training had been undertaken by nursing staff. If nursing staff were not available to act as a chaperone, receptionists were used. The majority of reception staff had undertaken informal training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. One staff member spoken with confirmed that they had not received any training but had read the chaperone policy which they felt gave sufficient information to fulfil the role. Both male and female staff were available to act as a chaperone. Not all administrative staff who would be expected to undertake this role had a criminal records bureau check undertaken by the disclosure and barring service. Following this inspection we were given assurances that a risk assessment had

been completed for administrative staff who also undertook chaperone duties and as necessary, where identified, a criminal records bureau check would be undertaken. We will check this at our next inspection of the service.

We discussed mental capacity act training with the practice manager. We were told that this training was included in the safeguarding level 3 training undertaken by clinical staff. However, non-clinical staff had not undertaken any training regarding the mental capacity act but had been given information produced by the Dudley Group of Hospitals regarding mental capacity.

### 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. We saw records to demonstrate that fridge temperatures were monitored on a daily basis. There was a clear policy for ensuring medicines were kept at the required temperatures and this policy had been reviewed on an annual basis.

We discussed the receipt, storage and recording of vaccinations received at the practice. We were told about the systems for checking and rotating stock. However the practice nurse confirmed that there was no written record of the batch numbers of vaccinations received on the premises and no records to demonstrate stock checks and rotation. All vaccines checked on the day of our inspection were in date.

Vaccines were administered by nurses using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs seen had been signed and were up to date. (A PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription).

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Staff told us that they checked that emergency medicines were within their expiry date and suitable for use on a weekly basis. However, processes in place were not robust as there was no documentary evidence to demonstrate that checks

## Are services safe?

were undertaken. All the medicines we checked were in date and fit for use. We were told that the medication kept in GPs bags was checked at least weekly but again there were no records to demonstrate this.

We were told about the systems in place to dispose of expired and unwanted medicines which were in line with waste regulations.

We discussed the safe storage of prescription pads with two of the GPs at the practice. We were told that some of the GPs did not use prescription pads, preferring to use computer generated prescriptions. However prescription pads were available at the practice and we could not find any evidence to demonstrate that a robust system was in place for the management and monitoring of prescription pads.

We discussed the systems for ordering repeat prescriptions with staff. All were aware of the systems in place and confirmed that an alert was available on patients' records to show when a patient had reached their limit of repeat prescriptions. The patient and the GP would be informed of this and an appointment would be made with the GP if necessary to review medication and health. We were told that patients could request repeat prescriptions by email or could ask at reception. On-line ordering for repeat prescriptions was being introduced in February and we saw that staff training had been arranged regarding this. Following our inspection we were told that on-line appointment booking and repeat prescription ordering had been introduced at the practice.

We discussed the systems in place for the management of high risk medicines such as insulin or methotrexate which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

A Community pharmacist visited the practice each week on a Wednesday. This pharmacist undertook a clinic and then completed any medication checks and audit work required. We were told about a recent audit regarding prednisolone and bone density (prednisolone is a steroid used to help control inflammatory and allergic conditions such as asthma, rheumatoid arthritis and colitis). The GP spoken with stated that the service provided by the community pharmacist was beneficial and provided support to GPs at the practice.

We were told that medication errors were discussed at clinical staff meetings. Minutes of meetings reviewed and staff spoken with confirmed this. We saw that significant event records had also been completed regarding any medication errors that had occurred.

Systems were in place to inform GPs and change patient records if any changes were made to a patient's medication via a secondary care service. A member of staff spoken with said that information was scanned onto the computer on the day that it was received.

### Cleanliness & Infection Control

We were told that an external cleaning company completed daily cleaning at the practice. We saw that cleaning records were kept. Details of the required frequency for cleaning areas of the practice and the responsibilities of cleaning staff was also recorded in cleaning schedules. We observed the premises to be visibly clean and tidy. Patients we spoke with and comment cards received confirmed that patients found the practice clean and had no concerns about cleanliness or infection control.

We discussed infection prevention and control with the practice nurses. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. We saw that this had been reviewed on an annual basis.

The practice nurses were the leads for infection control; both of these staff had undertaken further training to enable them to provide advice on infection control. We saw evidence that infection control audits had been carried out. Improvements identified had been completed such as the replacement of carpets with easily cleanable hard flooring.

Infection prevention and control measures in place included the use of personal protective equipment (PPE), wipe clean chairs and examination couches, disposable curtain screening (dated with the date of disposal), clearly labelled sharps bins and hand washing technique signage by sinks. We saw that hand washing sinks with hand soap; hand gel and hand towel dispensers were available in treatment rooms.

Spill kits were available in clinical areas. Staff were aware where spill kits were stored and when they should be used. This helped to ensure that any potentially infectious

## Are services safe?

substances were attended to by staff in a timely and effective manner. Spills of blood or bodily fluids need to be treated promptly to reduce the potential for spread of infection with other patients, staff or visitors.

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 in order to comply with the practice's infection control policy. There was no policy for needle stick injury; however signs were displayed on walls in treatment rooms detailing how to prevent needle stick injuries and also telling staff of the action to take if a needle stick injury occurred.

Healthcare workers have a duty of care towards their patients which includes taking reasonable precautions to protect them from communicable diseases. Immunisation of healthcare workers is therefore important as it may protect the individual from an occupationally acquired infection and also protects patients. We saw that the immunisation history of staff was recorded in their personnel files and we were told that all clinical staff had received the necessary immunisations.

We discussed the storage and disposal of clinical waste. We saw information which demonstrated that arrangements were in place for managing clinical waste.

We saw records to demonstrate that a legionella risk assessment had been undertaken in 2014 with the next assessment due to be completed in 2016 (legionella is a germ found in the environment which can contaminate water systems in buildings). The practice manager told us that the landlord of the premises undertook the necessary checks to reduce the risk of infection to staff and patients. The legionella risk assessment confirmed this.

### Equipment

The practice nurses that we spoke with told us they had sufficient equipment to enable them to carry out their duties including, assessments and treatments. The practice manager 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 a blood pressure monitor.

### Staffing & Recruitment

We looked at the staff file of a member of staff recently recruited. Recruitment systems were not robust and did not ensure that sufficient pre-employment checks were undertaken, for example there was no medical questionnaire, no explanation of gaps in employment history or proof of identification for one member of administration staff recently employed. The member of staff told us that their employment history was discussed at their interview. Interview notes that we saw did not demonstrate this. Disclosure and barring service checks (DBS) were not available for administration or nursing staff. Nursing staff had worked at the practice for many years and had not been subject to any DBS checks. Some of the administration staff were occasionally required to undertake chaperone duties and therefore required a DBS check. We were told that GPs were aware that these checks were now required and had developed a risk assessment for the newly appointed administration staff member and had commenced the process for requesting DBS checks for nursing staff. We will check this at our next inspection of the practice.

The practice had a recruitment policy that detailed the processes to be followed for checking the qualifications of potential clinical staff. We saw that this policy had recently been developed; we were told that this was the only recruitment policy available. However, the practice manager confirmed that a recruitment policy would be developed and forwarded to the CQC.

We were told that the practice was trying to recruit a member of administration staff to help ease the pressure at busy times of the day and to help ensure workload was more manageable.

We saw that relevant checks were completed to ensure clinical staff were up to date with their professional registration, for example nurses were registered with the Nursing and Midwifery Council (NMC). The practice also kept a record to demonstrate that GPs were registered on the performers list. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.

We were told that locum GPs were used at this practice on a regular basis. A locum pack had been developed which contained information for the locum GPs regarding practice

## Are services safe?

staff, systems and practices. We checked the records for one locum GP who had worked at the practice. Records demonstrated that appropriate checks had been undertaken before the locum joined the practice. This included, DBS checks, immunisation history, medical defence union information and evidence that the locum was on the performers list.

### Monitoring Safety & Responding to Risk

We previously inspected this practice in June 2014. We found that the fire risk assessment in place was due for review shortly after our inspection visit as was the legionella risk assessment. The risk assessment regarding the premises was brief.

During this inspection we saw the practice's fire and legionella risk assessments which were up to date. We were sent a copy of a risk assessment regarding the areas of the building used by this practice. The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We were told that the landlord of the building undertook regular checks of the building and risk assessments..

The practice had a health and safety policy and health and safety information was displayed for staff to see.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing that the majority of staff had received training in basic life support. A newly employed staff member had not undertaken this training. The practice manager confirmed that training for all staff had been booked for February 2015. Emergency

equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff who we asked knew the location of this equipment. A member of clinical staff told us that this equipment was checked regularly; however there were no records to confirm this. The practice manager told us that an emergency situation had arisen the day prior to our inspection which required the use of the practice's emergency oxygen which was used with success prior to the patient being transferred to hospital.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and actions recorded to reduce and manage the risk. Risks identified included power failure, computer failure, and access to the building. Areas of responsibility for staff were identified along with risks and actions recorded to reduce the risk. The document also contained relevant contact details for staff to refer to.

Staff told us about the systems in place to raise an alarm if they were in danger or threatened by a patient. We were told that panic buttons were available in each treatment room, computer systems also enabled a "silent alarm" to be pressed which alerted staff. Clinical staff spoken with confirmed that they had not been required to use any form of restraint and would only do so if the patient presented any danger to themselves or to others at the practice.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence, and from local commissioners.

Patients with long term conditions were reviewed by the GPs and the practice nurses to assess and monitor their health condition so that any changes to their treatment could be made. Two GPs had undertaken additional training regarding diabetes to further enhance the service provided to patients at the practice. These GPs took the lead role for diabetes and practice nurses undertook the annual health checks for these patients. Practice nurses led in asthma, smoking cessation, COPD and childhood immunisations. A phlebotomist visited the practice weekly and undertook blood tests for patients at the practice and for the wider community.

We were told that the practice were looking to introduce 'flags' on the computer system to alert staff if a patient was also a carer of a patient and for those patients on the practice's palliative care register. This information would be useful to ensure that staff were able to provide the level of support required and signpost patients to appropriate services if required.

We were told about the systems in place to avoid unplanned hospital admissions. Administration staff were responsible for ensuring that patient records were appropriately coded and that documentation was available in order to produce care plans. Patients were either visited at their home or if they were able they visited the practice. Care plans were written and kept in a folder in the reception. The practice manager was in the process of recording this information on the practice's computer system.

The practice referred patients appropriately to secondary and other community care services such as district nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enabled patients to choose which hospital they would prefer to be seen.

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

the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. We were told that the needs of some asylum seekers were met at the practice which had included the use of an interpretation service.

### Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management.

The practice had completed a number of clinical audits, for example a diabetes new drug audit which had been completed in line with NICE guidance and a primary care gout audit. One audit had completed a full cycle with the results analysed and all other audits were ongoing and their impact had yet to be assessed. Audits should be full cycle to show the initial audit, changes implemented and a second audit to demonstrate the improvements made.

The practice nurse delivered the childhood vaccination programmes. The practice was achieving a good uptake of vaccinations. We saw evidence that out of a total of 109 eligible children aged up to 12 months, all had received with their childhood vaccinations such as pneumococcal and meningitis C.

We were told about a risk assessment tool (Q risk for assessing cardiovascular risk) used for assessing the risk of having a heart attack or stroke over the next ten years and another risk assessment tool (Frax) used to identify those patients at risk of bone fracture. This assessed an individual's risk of fracture. Both of these risk assessment tools helped GPs detect and prevent unwanted outcomes for patients and make informed treatment decisions.

There were arrangements in place to ensure women received cervical smear tests by staff that were appropriately trained. Samples were sent to a local NHS hospital to be analysed and reported on in line with national guidance and recall systems.

We were told that the practice had not developed any care plans for patients with learning disabilities or for those with dementia.

### Effective staffing

# Are services effective?

(for example, treatment is effective)

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that the majority of 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 either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. GPs we spoke with said that they undertook the appraisal of all staff at the practice. The practice manager confirmed this and we were shown three appraisals that had recently been completed. We were told that clinical staff had their own learning programmes and managed these themselves.

Discussion with staff on the day and evidence we reviewed showed that staff had received training appropriate to their roles. Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and smoking cessation.

We looked at the induction records for a member of staff recently employed at the practice. We saw that a brief induction had been completed. We spoke with this member of staff who told us that they had a three month probationary meeting arranged with a GP and the practice manager to discuss their performance since employment at the practice.

## Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice policy outlined the timescales and responsibilities for all staff in passing on, reading and taking action on any issues arising from communications with other care

providers. The GP seeing 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.

We saw that the practice effectively shared information with other services, for example the out of hours service. Systems were in place to ensure that special patient notes were sent to out of hours providers so that important information was shared. (Special patient notes are information recorded about patients with complex health and social care needs used to alert or highlight any specific care requirements, long term care plans or any other item of useful information for the patient).

There was a national recall system in place for cytology screening which was carried out by the practice nurse. This ensured women received this important health check including their results in a timely manner.

We were told about the systems in place to ensure information was passed on to health visitors and district nurses who visited the practice regularly. This two way communication helped to ensure that all relevant staff were kept up to date with information about practice patients. Therefore helping care and treatment to be planned to meet patient's changing needs.

## Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. Staff were still receiving training on the system as it had been implemented within the last few months. However staff commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

# Are services effective?

(for example, treatment is effective)

Multidisciplinary meetings were held on a quarterly basis and a palliative care register was kept which recorded diagnosis, contacts and other useful information. This register was used to help optimize the quality of life for these patients and their families via the use of symptom control and good supportive care.

## Consent to care and treatment

GPs we spoke with confirmed that the Mental Capacity Act 2005 was included in training that they had undertaken regarding the protection of vulnerable adults and children. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice nurse was able to find information on the practice computer regarding mental capacity to assist them if required.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Two of the GPs at the practice conducted minor surgery, including joint injections in line with their registration. We asked about the processes of obtaining consent for this. One GP stated that they obtained implied consent as following consultation with the GP; the patient was required to make an appointment to receive the joint injection. The GP felt that the patient was giving consent by making the appointment. We were told that details of any discussions held including risks and benefits would be logged on the patient's record. We were shown a completed paper consent form signed by the patient regarding removal of a lump. The GP who undertook this procedure stated that they always obtained written consent for any minor surgical procedures that they undertook. A new detailed form had been developed to obtain patient consent to treatment to replace the form currently in use.

## Health Promotion & Prevention

The practice's performance for cervical smear uptake was 72% which was 2% lower than the average in the area. There was a policy to offer telephone reminders for patients who did not attend for a cervical smear. There was a named nurse responsible for following-up patients who did not attend screening.

The practice offered a full range of immunisations for children, flu and shingles vaccinations in line with current national guidance. We were told about flu immunisation clinics held on a Saturday morning. Patients were able to walk in and did not need to make an appointment. We saw minutes of clinical meetings that discussed these walk in clinics.

We were told about the systems in place for ensuring those people with long term conditions received the necessary health checks. Systems were also in place to contact the families of children who required immunisations who had not attended to have these undertaken.

Practice nurses completed new patient checks and NHS health checks for people aged between 40 and 74 years of age. The practice offered a range of health promotion and screening services which reflected the needs for this age group. Lifestyle advice was offered such as advice on smoking cessation.

We were told about the services provided for those patients with mental illness. A mental health link worker visited the practice twice per month. Patients could then be referred to the Early Access Service (EAS) which provided a single point of referral for GPs seeking to access services in Secondary Care including out-patient opinion.

We saw that information leaflets and posters were available in the waiting room and patients were signposted to other support services for example regarding mental health eating disorders.

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

GP partners at this practice were all male; however we were told that a female locum GP worked at the practice for six sessions per week. We were told that patients were offered an appointment with a clinician of the same sex as themselves wherever possible. A chaperone was offered if an intimate examination was to be undertaken by a GP of the opposite sex. We saw notices informing patients of the availability of chaperones. One GP that we spoke with confirmed that chaperones were always offered and patient records were updated to confirm whether the chaperone had been accepted or refused. Staff confirmed that they had acted as a chaperone when requested to do so.

We reviewed the most recent data for the practice from the national patient survey, 347 surveys were sent out to the practice population and 118 were returned. Overall patients were satisfied with their consultations with doctors and nurses, with 84% of practice respondents saying the GP was good at listening to them and 97% saying the practice nurse was good at listening to them. The results showed that 75% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 98% of patients said that the last nurse they saw or spoke to was good at treating them with care and concern. The practice had undertaken the general practice assessment questionnaire in January 2015 and 84 patients were surveyed. The results of this were made available to us. Results showed that generally people rated the practice as good or very good for the majority of questions asked. For example the doctor's patience with questions or worries, the doctor's caring and concern for you. These results were to be analysed at the next meeting of the PPG in January 2015.

We saw that a suggestions box was available in the waiting area to enable patients to make comments or suggestions but we were told that this was rarely used. The friends and family test had recently been implemented and we saw a box and information for patients. We were told that the practice had not received any responses as yet.

Patients completed CQC comment cards to provide us with feedback on the practice. We received three completed cards and all were positive about the service experienced.

Patients said that staff were professional in their attitude they felt that the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with nine patients on the day of our inspection. All told us they were happy with the care provided by the practice and said that staff were compassionate, GPs listened to what they had to say and treated them with respect and maintained confidentiality and privacy.

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.

The practice reception desk was shielded by glass partitions which helped keep patient information private. Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments. We observed an occasion when a patient requested information about another patient at the practice. Staff explained that they were not able to give this information. We saw that staff were careful to ensure that confidential information was kept private. The practice manager told us that all staff had signed a confidentiality statement and were aware of their responsibilities regarding confidentiality.

Photographs of practice staff with their names were on display in the waiting area. This helped patients identify staff who worked at the practice.

Before our inspection we reviewed information from the NHS Choices website. We saw that both positive and negative comments had been made about this practice. The practice manager told us that they were currently unable to respond to these comments due to a technical difficulty which was under review by NHS Choices staff.

### 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

## Are services caring?

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. However, the results of the national patient survey dated 2013 did not all align with these views. Whilst 93% of respondents to the questionnaire said that the last nurse they saw or spoke to was good at explaining tests and treatments and 94% said that the last nurse they saw or spoke to was good at involving them in decisions about their care, the results were not as high for the GPs (80% and 71% respectively). The results from the practice's own satisfaction survey showed that patients rated the practice as good (27%) very good (26%) and excellent (29%) for how thoroughly the doctor asked them about their symptoms and good (26%), very good (14%) and excellent (28%) for how well the doctor put them at ease. Patients rated the practice as good, very good or excellent for the majority of questions asked.

Staff told us that translation services were available for patients who did not have English as a first language. This helped to ensure that patients understood information given to them and were able to be involved in decisions about their care and treatment.

Care plans were in place for patients with a view to avoiding unnecessary hospital admissions. Administration staff explained their role in ensuring that care plans were in place, records were coded appropriately and completed care plans were given to the patient. We saw that computerised records contained an alert to notify staff that the patient was included in the unplanned hospital admissions register. We were told that all of these patients (160) had a care plan in place which was subject to regular review. Systems were in place to ensure that patient's records were updated following any hospital admission or outpatient appointment.

GPs spoken with told us that there were no care plans in place for those patients registered at the practice with a learning disability. Administration staff spoken with confirmed that these patients' records were coded to alert GPs but there would not normally be an annual review of this patient group as the practice had not signed up for this enhanced service.

Information we reviewed prior to our inspection from the quality and outcomes framework (QOF) identified that the practice was at an elevated risk due to the low number of patients diagnosed with dementia whose care has been

reviewed in a face to-face review in the preceding 12 months. The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months and the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months. We discussed these issues with a GP and were told that they were aware of the QOF domains in which they had performed poorly; they felt that this was due to poor advice but they were implementing systems to ensure these issues were addressed. 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

We discussed another area in which the practice was identified as underperforming regarding QOF targets. This related to blood pressure monitoring of patients with hypertension. We were told that all of these patients had recently been contacted by letter and asked to attend the surgery for a blood pressure review.

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

We were told about the systems in place to assess and manage the care of patients with long term conditions such as diabetes, asthma and COPD. The GP told us that where a need was identified they also assessed these patients for depression and anxiety. This helped to ensure that patient's emotional and physical health was kept under review. We were told that a register of carers was kept, although this information had not been included in patient records and was not used to ensure that carers received extra support, or to ensure vaccinations were offered to carers to try to keep them healthy.

We were told by a GP about how the practice strived to ensure that care and treatment was provided in a way that met patients' needs and wishes. The GP discussed five recent examples of how the practice had met individual patient's needs regarding their treatment, working closely with other services such as district nurses and MacMillan nurses. We were told about the support provided to the patient's families. All staff we spoke with displayed a caring and empathetic attitude.

## Are services caring?

Notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations.

One GP spoken with told us that families who had suffered bereavement were offered an appointment with their usual GP. Patients could also be signposting to a support service such as CRUSE or the Big White Wall. (CRUSE is a bereavement counselling service and the Big White Wall is an online service offering support to people who are anxious, feeling down, or not coping who support and who

help each other by sharing what's troubling them, guided by trained professionals.) If a need was identified, the patient would be signposted to the link worker for mental health who would make further referrals for cognitive behavioural therapy if required. We were told that staff had not undertaken any specific training regarding bereavement; however during our discussions with staff it was evident that staff gave priority to patients' needs and there was a caring culture amongst staff at the practice.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice told us how it delivered services to meet the needs of its patient population. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and diabetes.

There were nurse led services such as the vaccinations, cervical smear tests as well as disease management services which aimed to review patients with common illness and ailments. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated.

The practice had a palliative care register and currently had quarterly meetings we saw meeting dates planned for 2015 which were to be held on a monthly basis. We were told that future meetings would involve a multidisciplinary team of staff such as virtual ward staff, district nurses, heart failure team, Macmillan nurse and practice staff.

There had been very little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them. This also included appointments with a named GP or nurse. Home visits were made to patients if required.

The practice had an active patient participation group (PPG). The practice manager told us that they were continually recruiting for new members. A PPG noticeboard gave information about future meetings and about joining the PPG. The PPG is a useful tool to help the practice engage with a cross section of the practice population and obtain patient views. PPGs are a group of patients who meet on a regular basis and are involved in decisions that may lead to changes to the services the practice provides.

### Tackle inequity and promote equality

Car parking spaces were provided at the back of the building with disabled spaces being available to the front. Disabled access was provided to the practice and we saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. A hearing loop system was in place but we were told that this was not used by patients. The method of

calling patients to their appointments would not be suitable for those patients with visual impairments but we were told that staff were aware who these patients were and gave verbal prompts to these patients.

We were told that an interpreting service was available and patients should inform the practice before their appointment if this service was required. We saw signs displayed in the waiting room informing patients of the interpreting service available.

### Access to the service

We reviewed the results of the 2013 national patient survey. The results relating to access to the service showed low satisfaction. Only 48.3 % of patients rated their experience of making an appointment as good or very good, 67% of patients who responded to the survey found it easy to get through to the surgery by telephone and 48% of respondents with a preferred GP usually got to see or speak to that GP.

We discussed access to appointments with the practice manager and were told that extra appointments had been made available to help manage capacity and opening times had been amended following a review undertaken by practice staff. Extended opening hours were provided on a Tuesday with appointments being available from 7am to 11am and then from 2pm until 6pm. This was particularly useful for patients with work commitments. The practice manager told us that extra GP sessions with a female GP had helped to improve access to the service and gave patients the choice of seeing a male or female GP. The practice opening times varied on different days of the week. For example surgery times were 9am – 12pm on a Monday, Wednesday and Friday and 8am – 12pm on a Thursday. Afternoon surgery times were 4pm – 6pm on a Monday and Wednesday and 3pm – 6pm on a Thursday and Friday. A member of the PPG that we spoke with felt that appointment systems and access to services continued to improve.

Reception staff told us about the system for booking appointments. We were told that patients could book an appointment over the telephone, face to face at the surgery or on-line. Patients could book appointments in advance to see a named GP. Various systems were in place to aid patients to access the service; patients were also able to

# Are services responsive to people's needs?

(for example, to feedback?)

order repeat prescriptions on-line. Text messages were sent to remind people of their appointments. We were told that these reminders were sent one week before and again one day before the patient's appointment.

Appointment slots were available each day to be filled by people who may need to see a GP in an emergency. If these appointments slots were all used up, we were told that the patient could speak with the GP over the telephone who would then either conduct a telephone consultation or arrange an appointment as necessary.

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

## **Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. The practice manager was the designated responsible person who handled all complaints in the practice.

We could not see any information in the reception or waiting area to help patients understand the complaints

system. 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 eight complaints received at the practice in the last twelve months. We reviewed one of these complaints in detail and found that a robust complaint system had been followed; details of investigations held were available along with a summary of lessons learnt and actions to take. We saw minutes of meetings which demonstrated that complaints were discussed at clinical staff meetings. However, we saw that the final outcome letter did not record the details to enable the complainant to escalate their concerns further if they were unhappy with the outcome of the practice's investigation. We looked at the practice's complaints policy which was in line with national guidelines and saw that details of the Parliamentary and Health Services Ombudsman (PHSO) were recorded. The PHSO has a role to investigate complaints where individuals feel that they have been treated unfairly or have received poor service from government departments and other public organizations including NHS in England.



# 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 saw that the practice's statement of purpose which recorded their vision, aims and objectives was on display in the waiting room for patients to see. Staff that we spoke with were caring and showed empathy towards patients.

We spoke with two members of staff and they both knew and understood the vision and values and knew what their responsibilities were in relation to these. All staff who we spoke with were aware of improvements required following previous inspections and were able to give evidence of how improvements had been implemented.

The practice had not notified CQC of some changes in the partnership of the practice. Changes are required to ensure that the CQC register is up to date regarding the current partners at the practice. We were told that the practice is in the process of addressing these registration issues.

### Governance Arrangements

The practice had not completed the information governance (IG) toolkit. The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. One of the GPs spoken with was aware of the practice's performance in relation to other practices within the CCG area and confirmed that the practice was moving up the quality dashboard and received feedback to confirm this from the local CCG.

### Leadership, openness and transparency W3

We saw that there was a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a GP was the lead for safeguarding. Staff were aware that there were lead roles and knew who to speak with if they needed any

guidance or had concerns. Staff we spoke with were clear about their own roles and responsibilities and said that the practice manager and GPs were approachable and offered assistance if required.

Staff told us that they felt supported and also supported each other as necessary. We were told that staff worked well as a team and also that they felt appreciated for the work that they did.

We saw the minutes from weekly clinical meetings. We were told that these meetings were often informal and detailed minutes were not always taken. We were told that full practice meetings were not held as often but were planned to take place on a monthly basis in 2015. We were shown a schedule of meeting dates which had been arranged for 2015.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction and disciplinary policy which were in place to support staff.

### Practice seeks and acts on feedback from users, public and staff

The practice had an active patient participation group (PPG) which had five members. The PPG contained representatives from various population groups; including working age and older age people. The PPG had carried out a face to face survey of 100 patients in February 2014. The practice manager showed us the analysis of the last patient survey which was compiled by two PPG members. An action plan had been generated to address issues raised. We met with members of the PPG during our inspection. We were told about changes made at the practice following PPG suggestions, for example the telephone number to the practice has been changed as a direct result of patient feedback. Disabled parking has been made available at the front of the practice and we were told about the Saturday morning walk in flu clinics.

We were told that the practice recognised the importance of the PPG and were supportive, open and honest. Patients were able to attend a walk in session at the practice and representatives from winter warmth and Age UK were invited to attend. Elderly patients were identified and invited to attend. We were told that this event was well attended and was planned to be repeated due to the good feedback received.

# Are services well-led?

Good 

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

We were shown the results of the General Practice Assessment questionnaire which was undertaken in January 2015. A total of 84 patients were surveyed and were asked questions about staffing, opening times, ease of access to GPs, waiting times, phone contact and consultations. The majority of patients rated the services provided as good, very good or excellent to the majority of questions asked. We were told that the PPG were going to review the outcome of this survey at their next meeting.

We saw a thank you letter from a patient who praised the practice for their immediate attention and referral to hospital, they commented on the positive results following the practice's prompt action.

We were told that the practice manager and GP had an 'open door' policy meaning that staff could speak with them at any time. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

## Management lead through learning & improvement

The practice had responded to feedback on service delivery from the PPG as well as other patients through surveys and complaints. We saw that changes had been made to improve service as a result of feedback, for example a change was made to the practice's telephone number at the request of patients.

Staff told us that the practice supported them to maintain their clinical professional development through training. Staff told us that the practice was very supportive of training and we were told about future training for staff.

The practice had completed a number of clinical audits, for example a primary care gout audit, an audit regarding management of chronic heart failure (May 2014) and a diabetes new drug audit. One audit had completed a full cycle with the results analysed and all other audits were ongoing. A full audit cycle involved an initial audit, changes identified implemented and then a re-audit to demonstrate improvements achieved. The benefits to the practice and patients following clinical audit were discussed.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients.