

# Brook Square Surgery

## Quality Report

Brook Square Surgery  
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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?	Requires improvement	
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 a comprehensive inspection of Brook Square Surgery on 12 November 2014.

We rated the practice overall as Good.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. However, we identified during the inspection an area of concern regarding the safety of some patients.
- The practice had systems in place for monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example annual health checks and cervical smears. There was a good skill mix among the staff group with staff having a range of qualifications.

- Patients told us they were treated with dignity and respect. They said staff listened, were helpful, supporting and caring.
- The practice was responsive to the needs of patients and took into account any comments, concerns or complaints to improve the practice. The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.
- The practice was well led, with an accessible and visible management team with clear direction. Governance systems and processes were in place and quality management information was available and used to improve outcomes for patients.

We saw one area of outstanding practice:

# Summary of findings

- The practice had appointed a Health and Social Care Co-ordinator to lead on the management of patients on the care management register. This role involved close working with nursing and residential homes to devise care plans for patients.

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

Importantly, the provider must:

- The practice must ensure they assess and manage all risks and put actions in place to mitigate risk in a timely way. Since June 2014 the practice had assumed that all GPs had medical indemnity but one GP did not. Whilst the practice had attempted for three months to confirm the GP was insured, at the time of our inspection the practice had not received

confirmation and had not taken steps to ensure the GP was insured in the interim. The practice responded appropriately on the day of the inspection to mitigate the identified risk and this issue was referred to NHS England. We believe that this issue pertains to all of the population groups, although overall our view is that you provide good services that are effective, caring, responsive and well led, for each of the population groups.

The provider should:

- Ensure the safeguarding lead is trained to Level 3 in safeguarding adults and children.

**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 requiring improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. However, the practice had failed to assess and manage an identified significant risk and as a result failed to put actions in place to mitigate the risk in a timely way.

Requires improvement



### Are services effective?

The practice is rated as good for effective. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff considered and implemented guidance from the National Institute for Health and Care Excellence (NICE). The practice had effective systems in place for monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example annual health checks and cervical smears. There was a good skill mix among the staff group with staff having a wide range of qualifications. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams and with other practices.

Good



### Are services caring?

The practice is rated as good for providing caring services. Patients said staff listened, were helpful, supportive and caring. They said staff treated them with dignity and respect. Information was made available to patients to sign post them to other support services and organisations. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



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

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Extended appointments were available on a Monday from 8am to 8pm and clinics were offered over a lunchtime period Monday to Friday. We received mixed feedback from patients regarding the appointment system and accessibility to the practice via the

Good



# Summary of findings

telephone. However, records showed the practice was actively monitoring how the appointment system was working for patients and staff since the merger in May 2014 and it was evident that action had been taken following patient and staff feedback in relation to this area. For example, additional phone lines had been installed and more GP appointments had been made available. Urgent appointments were available the same day and home visits and telephone consultations made available where required.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evident.

## **Are services well-led?**

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to achieving the practices vision. There was a clear leadership structure with staff having clearly defined roles and responsibilities. Staff told us they felt supported by management. The practice held regular strategic planning meetings to review their performance. The practice proactively sought feedback from staff and patients, which it acted on. There were systems in place to monitor and improve quality and identify risk to patients, although we saw one example where a risk had not been acted on.

**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 good for the care of older people. The practice had recently appointed a health and social care coordinator to lead on the management of patients on the care management register. The role had started to engage with nursing and residential homes to devise care plans and build on multi-disciplinary working for these patients. For example we saw the practice had reviewed the list of patients who lived in nursing or residential homes who had been admitted to A&E as an emergency to see if the admission could have been avoided. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, vaccinations for shingles. It was responsive to the needs of older people, and offered home visits and rapid access appointments which included same day telephone consultations.

Good



### People with long term conditions

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Clinical staff specialised in areas such as Heart Failure, COPD, Diabetes and Asthma. The practice runs specific nurse led clinics for patients with long-term conditions. The practice had an effective recall system in place. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health care professionals to deliver a multidisciplinary package of care. It was responsive to the needs of this patient group, and offered home visits and rapid access appointments which included same day telephone consultations.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, children and young people who had a high number of A&E attendances. The practice offered a full range of immunisations for children.

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked

Good



# Summary of findings

jointly with the community midwife and health visitor and offered midwife and health visitor led clinics at the practice and visited patients in their home. The practice offered sexual health services and participated in the 3Cs & HIV programme.

Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

The practice was aware of the high number of safeguarding issues for this patient group and had established close working relationships with the safeguarding team. Staff knew how to recognise signs of abuse and they were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

## **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 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 offered extended appointments on a Monday from 8am to 8pm and all clinics were available during the lunchtime period. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. We saw the practice was actively promoting health checks for these patients.

Good



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

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice had recently appointed a health and social care co-ordinator to lead on the management of patients on their care management register. The role had started to engage with nursing and residential homes to devise care plans and multi-disciplinary working for these patients. For example we saw the practice had reviewed the list of patients who lived in nursing or residential home who had been admitted to A&E as an emergency to see if the admission could have been avoided. The practice held a register of patients with a learning disability and carried out annual health checks for them either at the practice or in their home. The practice offered longer appointments for people with a learning disability. The practice held a register of vulnerable patients as part of the care management register. All these patients had a care plan and were offered same day appointments. The patients also held a register of carers and these patients were offered an annual health check.

Good



# Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and referred patients appropriately. For example the practice area had a high number of patients with alcohol addictions. The practice worked closely with other services to support patients' rehabilitation.

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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health; for example the Addictive Behaviour Service and Primary Care Mental Health Worker (CAMHS). The practice had a high number of patients with alcohol problems and worked closely with the drug and alcohol workers around prescribing. Two GPs at the practice had a specific Royal College of General Practice (RCGP) certificate in drug and alcohol addiction. The practice had carried out an audit of patients on the mental health register to ensure these patients were being appropriately managed.

**Good**





# Summary of findings

## What people who use the service say

We spoke with three patients who were using the service on the day of our inspection and reviewed 37 completed CQC comment cards. The majority of feedback from patients was positive. Patients described the practice as excellent. They said staff were helpful and caring and that

they were treated with dignity and respect. However, some patients told us they had experienced difficulty accessing appointments and getting through to the practice via the telephone.

## Areas for improvement

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

The practice must ensure that they assess and manage all risks and put actions in place to mitigate identified risk in a timely way.

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

The practice should ensure that staff have completed safeguarding training in adults and children to the required level.

## Outstanding practice

The practice had appointed a Health and Social Care Co-ordinator to lead on the management of patients on

the care management register. This role involved close working with nursing and residential homes and building on multi-disciplinary working to improve the outcome for patients on the care management register.

# Brook Square Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a second CQC inspector. The team included a GP and a practice manager.

### Background to Brook Square Surgery

Brook Square Surgery, Trafalgar House, 41 – 44 Trafalgar Street West, Scarborough, YO12 7AS is situated in Scarborough town centre. The registered patient list size of the practice is 11,468. The overall practice deprivation is higher than the England average. Brook Square Surgery was formed in May 2014 as a result of a merger of two practices; Trafalgar and Norwood.

There are eight GP partners and one salaried GP. The clinical nursing team is made up of a nurse practitioner, a senior practice nurse, five nurses and three health care assistants. There is also a practice manager, practice support team, data quality team and a business support team.

Brook Square is a training practice for GPs. The practice currently has one GP registrar who is a fully qualified medical practitioner who is completing the extra training required to become a GP.

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

The practice has opted out of providing out-of-hours services to their own patients. Patients use the 111 service when the practice is closed. Patients are seen by Primecare out of hours.

### 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. 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.

This provider had not been inspected before and that was why we included them.

We were unable to review data from other data sources, for example the National Patient GP Survey, General Practice High Level Indicators and General Practice Outcome Standards as this practice had only been in existence since May 2014. Current data that was available related to previous performance of the two individual practices prior to the merger. No data references have been included in this report unless related directly to Brook Square Surgery.

### How we carried out this inspection

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

Is it safe?

Is it effective?

# Detailed findings

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 November 2014. During our visit we spoke with three GPs, the senior practice nurse, two nurses, a health care assistant, the practice manager and a range of other data quality/administrative support managers and staff. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. These included systems for reporting incidents, acting on national patient safety alerts, recalling patients to the practice as well as responding to comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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

There were comprehensive policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible.

Despite this, we identified the practice had failed to assess and manage an identified significant risk and as a result failed to put actions in place to mitigate the risk in a timely way.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We were shown records of significant events that had occurred since January 2013. Records showed significant events were discussed routinely at clinical meetings which took place every month. There was evidence that the practice had learned from significant events and the findings were shared with relevant staff and learning identified and actioned. For example; a process had been put in place in reception to check the practice had received all INR results. All staff knew how to raise an issue for consideration at practice meetings and felt confident and encouraged to do so. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology, offered to meet with the practice staff and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. We saw examples of

action the practice had taken in response to safety alerts. They also told us alerts were discussed at practice meetings and information disseminated to staff who were not present at the meetings.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that most staff had received relevant role specific training on safeguarding children but not adults, although we were shown evidence that this was planned for 2015. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. We were told they had well established relationships with the safeguarding lead for the area.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained to Level 3 for children but not adults. GPs are required to be trained (to Level 3) in order for them to fulfil their role as safeguarding lead. All staff we spoke to were aware of the lead and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. Staff told us about the systems they had in place for monitoring vulnerable patients. For example; identifying children with a high number of A&E attendances and following up children who failed to attend appointments for childhood immunisations.

There was a chaperone leaflet available for patients in the practice waiting area and nursing staff acted as chaperones.

### Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were found to be stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures and which described the action to take in the event of a potential failure. The temperature of the fridges,

## Are services safe?

used specifically for the storage of medicines and vaccines, were regularly checked and recorded. The cold chain process of keeping medicines at the correct temperature range was followed by staff.

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

Vaccines were administered by the practice nursing team using protocols that had been produced in line with legal requirements and national guidance. We saw evidence that the practice nursing team had received appropriate training to administer vaccines.

The practice staff followed a repeat prescribing protocol which was in line with national guidance. Staff described how changes to patients' medication and repeat prescriptions were managed. Staff told us how they managed prescriptions for those patients that had not collected them. There was a system and protocol in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example; patients who were prescribed Amber Drugs. These are drugs that should be initiated by a specialist, and which require significant monitoring on an on-going basis.

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

Any medicines alerts that were received were reviewed by the practice manager and then disseminated to all clinical staff. We were provided with an example of a recent alert relating to the medicine Midazolam and the action the practice had taken following the alert. Alerts of this nature were discussed at practice meetings. Records also showed the practice regularly reviewed their prescribing against guidance and engaged with the CCG around medicines management. The practice received an annual prescribing visit from the CCG.

### Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Cleaning schedules were in place and cleaning records were kept. Patients told us the practice was always clean. The practice met regularly with the cleaners to ensure their adherence to infection control guidance.

The practice had a lead for infection control who had undertaken training to enable them to provide advice to staff on managing infection control at the practice. However, records showed not all staff had completed infection control training. Infection control audits were completed, issues identified and actions recorded.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Sharps bins were available and appropriately stored. Bins with lids and foot pedals for the disposal of general and clinical waste were in place. Special kits to be used in the event of spillage of blood or body fluids were available and stored appropriately. A needle stick injury policy was in place. Hand wash and safe hand washing guidance was displayed in treatment rooms. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice had arrangements in place to segregate patients if required.

We looked in the clinical areas and found the majority of them to be satisfactory. However; we did see unsuitable flooring in one clinical room where some clinical procedures were taking place. The practice was aware of this issue, had risk assessed and was exploring alternative arrangements, although no date for replacement was provided to us. Equipment that was used for procedures such as smear tests and for minor surgery were disposable which would reduce any risks of infection to patients. However, we found a small number of syringes that had passed their sterile expiry date which could have been used by clinical staff.

The practice had a policy for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings).

# Are services safe?

## Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Specific staff had key roles in checking and managing the maintenance of equipment. Staff confirmed 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 thermometers. All the equipment we looked at was in working order.

## Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that was regularly reviewed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw minutes of staff meetings where staffing was regularly discussed with mitigating actions put in place to ensure there was enough staff on duty at all times. We saw evidence that the practice had made more GP appointments available in response to patient feedback. There were arrangements in place for requesting annual leave to ensure all roles were adequately covered.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

## Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A health and safety policy was in place and information relating to health and safety was made available to staff.

The practice did not keep a central log of identified risks. Identified risks were recorded in area specific individual risk assessments, for example fire and fire doors. Each risk was

assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that most risks were discussed at GP partners' meetings and within team meetings.

Despite this the practice had failed to assess and manage an identified significant risk and as a result failed to put actions in place to mitigate the risk in a timely way. Since June 2014 the practice had assumed that all GPs had medical indemnity but one GP did not. Whilst the practice had attempted for three months to confirm the GP was insured, at the time of our inspection the practice had not received confirmation and had not taken steps to ensure the GP was insured in the interim. The practice responded appropriately on the day of the inspection to mitigate the identified risk and this issue was referred to NHS England.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in being able to respond to a medical emergency. Emergency equipment was available including access to oxygen, pulse oximeter and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines for use within the practice were within their expiry date and suitable for use. All these medicines we checked were in date and fit for use. We checked the contents of GP bags and found the drugs were within date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. However, staff at the practice did not have access to the emergency numbers when not in the office.

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

## Are services safe?

they practised regular fire drills. There were designated staff at the practice to co-ordinate an evacuation of the building in the event of an emergency and information was displayed within the practice.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance accessing supporting information from the NICE and from local commissioners. Staff were skilled in specialist areas which helped them ensure best practice guidance was always being followed. We saw minutes of practice meetings where new guidance was discussed, the implications for the practice's performance and patient outcomes were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Staff we spoke with and the evidence we reviewed demonstrated that there were appropriate clinical and nursing leads in specialist clinical areas such as diabetes, heart disease and asthma and the practice nursing staff supported this work which allowed the practice to focus on specific conditions. The practice had management plans in place to support those patients with long term conditions such as asthma, diabetes and chronic obstructive pulmonary disease (COPD). This was confirmed by patients we spoke with.

The practice had effective systems in place for monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example annual health checks and cervical smears. There were also systems in place for reviewing patients who had recently been discharged from hospital and who had changes in their medication.

### Management, monitoring and improving outcomes for people

The staffing structure in place at the practice showed teams and staff within those teams had clearly defined roles in monitoring and improving outcomes for patients. For example: GPs were leads in areas such as safeguarding; medicines management and QOF. The nursing team lead in areas such as Chronic Disease Management, sexual health and health promotion. The practice management team led in areas such as quality management. The practice support team led in areas such as management of repeat

prescriptions, referrals, recalls of patients to the practice and appointments and the business support team led in areas such as completing data returns for the CCG. We saw evidence that the practice had enhanced services available at the practice to improve the patient experience.

The practice showed us a range of clinical audits they had completed. Examples included an audit of familial hypercholesterolemia; Coeliac screening in irritable bowel syndrome (IBS), prescribing of oral nutritional supplements and an audit of patients on the mental health register who had up to date reviews for co-morbidity. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example the coeliac screening audit showed the need to increase awareness of the need to screen patients presenting with new systems of IBS and whose systems of IBS have not improved. Records showed this had been discussed with clinical staff. We also saw other changes, for example the new patient questionnaire form had been amended to include the question whether patients had a history of high cholesterol and a range of actions agreed in relation to patients on the mental health register.

Evidence showed the practice was proactive in responding to data collected to improve outcome for patients. For example we saw the practice had reviewed the list of patients who lived in nursing and residential homes who had been admitted as an emergency to A&E to see if the admission could have been avoided. We saw evidence the practice carried out clinical audits as a result of feedback from the CCG. For example the practice had carried out an audit of the prescribing of oral nutritional supplements as the practice had been identified as a high prescriber of this medication. The practice had clear records to show how they had evaluated the service and documented the success of any changes. The practice used the information collected for the QOF and Local and Direct Enhanced Services (LES and DES) to monitor outcomes for patients. The practice also participated in local benchmarking. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Systems were also in place for assessing the performance of non-clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.



# Are services effective?

(for example, treatment is effective)

Staff spoke positively about the culture in the practice around audit and quality improvement. We saw specific examples where outcomes for patients had been improved. This included the management of patients who were on the medication warfarin. The practice had invested in software and trained staff in anticoagulation management at the practice so that all patients could be managed at the practice.

## Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the staff group with staff having a range of qualifications. For example some GPs had a Diploma of the Royal College of Obstetricians and Gynaecologists and Diploma in Dermatology. Nurses had Diplomas in Diabetes and Health Care, Chronic Obstructive Pulmonary Disease (COPD) Diabetes and Family Planning. GPs were up to date with their appraisals and revalidation requirements. Every GP is appraised annually. A Responsible Officer from NHS England makes a revalidation recommendation to the General Medical Council (GMC) (normally once every 5 years) and the GMC then makes the decision whether or not to revalidate the GP and continue to practice and remain on the performers list).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. However, we identified that role specific training was not always completed. For example, infection control and safeguarding adults. As the practice was a training practice, doctors who were training to be qualified as GPs were supported with their appointments and had access to GP trainers throughout the day for support. The practice had engaged with the CCG and had implemented competency assessments for health care assistants. We were told by staff that they were not expected to complete roles outside of those tasks they had been assessed or trained as being competent to do so.

The practice utilised local apprentice schemes for employing some staff. We saw evidence to show apprentices had been supported to gain qualifications and develop into more advanced roles.

## Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Minutes of meetings showed changes or updates from other professionals were discussed and action taken where required. Arrangements were in place to ensure information was passed on to staff who could not attend practice meetings.

The practice provided a range of enhanced services, for example; a range of immunisations such as shingles and pneumococcal and minor surgery. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice did not hold any formal documented multi-disciplinary meetings and the practice acknowledged to establish these following the merger. However, we were told they had effective informal working relationships with other professionals, for example district nurses, health visitors and palliative care nurses.

## Information sharing

There was effective communication and information sharing and decision making about a patient's care across all of the services involved, both internal and external to the practice. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. 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).

The practice had systems to provide staff with the information they needed, clinical and non-clinical. Staff used an electronic patient record to coordinate, document and manage patients' care and all staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that

# Are services effective?

(for example, treatment is effective)

audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. Systems, such as electronic messaging and team meetings were also used for sharing non-clinical information with staff.

The practice had implemented the Summary Care Record (SCR) which meant they uploaded any changes to a patient's summary information, at least daily. This meant anyone treating patients could have access to their full medical record. The practice made patients aware on their website that patients could opt out of this scheme. The practice had partially implemented and was working towards full implementation of GP2GP record transfers by the end of March 2015. This meant that patients electronic records would be transferred much sooner when patients moved between practices.

## Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and was able to describe how they implemented it in their practice.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions, for example minor surgery and implants which practice staff followed.

## Health promotion and prevention

The practice had a range of information available for patients displayed in the patient waiting area and on the

practice website relating to health prevention and promotion. This included information on sexual health, children's health, long term conditions such as asthma, information for people who suffered from mental ill health and learning disabilities, and general health promotions that included smoking cessation, bowel cancer and alcohol awareness.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed, and access to support and treatment was available as soon as possible.

The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example we saw minutes of a staff meeting which showed that the list of vulnerable patients had been reviewed to ensure that it was relevant and up to date. The practice staffing structure included a specific data quality team who were responsible for the recall of patients to the practice for a range of areas. This included recalling patients for an annual review who were on a certain contraception, annual health checks and childhood vaccinations. They also had systems for reminding patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We saw evidence that the practice was pro-active in following up patients who did not attend for their immunisations; working in conjunction with health visitors.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We were unable to review data from the national GP patient survey for this area as the last survey was conducted prior to the merger of the two practices and therefore no data was available.

The majority of patient feedback from the CQC comments cards was positive about the way patients were treated by staff. Patients described staff as excellent. They told us they were treated with dignity and respect and that staff listened, were helpful, supportive and caring. Two comments were less positive but there were no common themes to these. We also spoke with three patients on the day of our inspection and they too were positive about their experience and the way they were treated.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were 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 told us they had experienced some issues with confidentiality in the reception area and had taken steps to remedy this and were keeping this issue under review. A separate consultation room was available for reception staff to use if needed.

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

We were unable to review data from the national GP patient survey for this area as the last survey was conducted prior to the merger of the two practices and therefore no data was available.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Translation service information was also available on the practice website. The practice told us they discussed and assessed the most suitable way of communicating with patients. For example, records showed the practice had discussed the need to ensure they effectively communicated with the increasing Polish community and had put measures in place to ensure appropriate communication around the need to reduce A&E admissions was shared. The practice also offered extended appointments for patients whose first language was not English. The practice also utilised a GP at the practice who was fluent in Czech, Balochi, Urdu, Sindi, Punjabi and Brohi and who could communicate in Slovak and was currently learning Polish.

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

The patients we spoke to on the day of our inspection told us that staff responded compassionately when they needed help and provided support when required. The practice provided information and support to patients who were bereaved and for carers. The practice provided literature and signposting to support groups and organisations within the practice and on the practice website. The practice maintained a list of carers and they were offered an annual health check.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The practice had recognised that since the merger that access to clinicians had become an issue. They had put in place short term measures by increasing the number of appointments available and in the long term had opted to recruit an additional GP.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them, and other practices to discuss local needs and service improvements that needed to be prioritised. The practice participated in providing data returns to the CCG and used this information to monitor and improve their performance. For example the practice had submitted actions plans to the CCG to reduce accident and emergency unplanned admissions.

### Tackling inequity and promoting equality

The practice had access to online, telephone and had a contract in place to access face to face translation services. Staff told us how they assessed the most appropriate way to communicate with patients.

The practice did not provide specific equality and diversity training for staff; although staff were clear that all staff were treated equally. We saw no evidence of discrimination when making care and treatment decisions. Interviews with the clinical staff demonstrated 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.

The practice was situated across two floors, accessed via stairs or lift. There was sufficient space in the practice to accommodate patients with wheelchairs and prams and to allow easy access to treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The seats in the waiting area were all of one height and size. There was no variation for diversity in physical health. Audio loop was available for patients who were hard of

hearing. The practice had put measures in place to support patients who required disabled parking spaces when visiting the practice as there were no allocated disabled parking spaces available to patients.

### Access to the service

We were unable to review data from the national patient survey for this area as the last survey was conducted prior to the merger of the two practices and therefore no data was available.

The practice was open 8am to 6pm, Tuesday to Friday and offered extended appointment availability on a Monday from 8am to 8pm. Clinics were also offered over the lunchtime period.

The practice website provided patients with a range of information on their website. This included information on how to book and cancel appointments, how to arrange urgent appointments and home visits. There was also information about how patients could receive urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for people who needed them; this also included appointments with a named GP or nurse. Arrangements were in place for weekly visits to a local care home.

We received mixed feedback from patients regarding the appointment system and accessibility to the practice via the telephone. However, records showed the practice was actively monitoring how the appointment system was working for patients and staff since the merger and it was evident that action had been taken following patient and staff feedback in relation to this area. For example, additional phone lines had been installed and more GP appointments had been made available. The practice was keeping this area under review. Patients also told us they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

# Are services responsive to people's needs?

(for example, to feedback?)

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

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

Patients knew how to raise concerns or make a complaint. Information on how to complain was made available to patients. We looked at eighteen complaints between December 2013 and October 2014 and found these were handled satisfactorily and had been dealt with in a timely and person centred way. Records also showed that complaints were referred for discussion at management meetings where learning points were discussed.

# 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. The practice mission statement was displayed within the practice waiting area. The practice had in place a strategic plan and met regularly to review their progress against the plan.

All the staff we spoke with were clear about the practice's mission statement and knew what their responsibilities were in relation to these.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in paper format. We looked at 10 of these policies and all had been reviewed and were up to date. Records showed policies and procedures were discussed at staff meetings and where relevant any changes or action required by the practice was recorded.

There was a clear leadership structure in place at the practice. The practice had clearly defined lead areas of responsibility for all members of staff and clearly defined workflows throughout the practice. All the staff we spoke with were clear about their own roles and responsibilities and those of their colleagues. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes. The practice had arrangements in place for completing clinical audits and monitoring against the QOF, LES (Local Enhanced Services) and DES (Direct Enhanced Services) which were used to monitor quality and performance of the practice. There were also mechanisms in place for discussing and addressing areas for improvement.

Records showed workforce planning and succession planning was regularly discussed at practice meetings and actions put in place to address pertinent issues. For example, records showed the practice had put in place long term, medium term and short term actions in relation to improving access to clinicians at the practice.

The practice did not have a central register of risk but carried out a range of individual risk assessments. Records showed most risks were discussed and action plans implemented to mitigate the risk. For example the risk of patients accessing the practice via the telephone had been discussed and actions put in place to reduce the risk.

### Leadership, openness and transparency

The practice had in place an annual schedule of meetings which ensured that all staff were regularly involved in attending meetings. This included practice meetings, all staff, clinical, strategic planning and case management meetings. We saw evidence that staff had raised issues at these meetings and they had been discussed, considered, and where appropriate action taken. The practice also formed working groups when new initiatives were being introduced into the practice.

The practice manager was responsible for human resource policies and procedures. A staff handbook was available for staff to refer to and to support them in their employment. We reviewed a number of policies, for example sickness management, study and training and grievance and found these had recently been reviewed.

Staff told us the meetings and information sharing at the practice helped them keep up to date with new developments and any issues. It also gave them an opportunity to make suggestions and provide feedback to the team. Staff told us there was an open culture at the practice and that they were encouraged to have a voice.

### Practice seeks and acts on feedback from its patients, the public and staff

The practice had not formally gathered feedback from patients since the merger. We discussed this with the practice manager who informed us they planned to gather patient feedback formally early in 2015 as they felt this would be a more beneficial timescale following the merger. However, it was evident that the practice was actively responding to feedback and complaints following the merger and had taken action as a result of feedback.

The practice had an active patient participation group (PPG). The last PPG reports related to prior to the merger.

The practice did not formally gather feedback via a survey but staff were encouraged to provide feedback in other ways; for example through staff meetings, away days, appraisal and lunch time discussions. Staff told us they

# Are services well-led?

Good 

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

would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and was readily available to staff.

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

Staff told us that the practice supported them to develop through training and mentoring. Staff could access training specific to their role and to meet the needs of the practice.

Staff told us the practice encouraged learning and improvement through meetings and staff appraisals. However, records showed that training in areas such as infection control and safeguarding for adults was not completed for all staff.

The practice was a GP training practice. It had two GP trainers and was involved in the vocational training of fully qualified doctors who wished to enter general practice.

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

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers  <b>The practice had failed to assess and manage a risk relating to the health, welfare and safety of patients and others who may be at risk from the carrying on of the regulated activity.</b>