

# Munro Medical Centre

## Quality Report

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

## Ratings

### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Munro Medical Centre on 5 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for 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 and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

### Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



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

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



# Summary of findings

## Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. 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 and held regular governance meetings. The practice was able to demonstrate how it dealt positively with poor performance from staff.

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient reference group (PRG) was active. Staff had received 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Figures showed that the practice was performing above national averages in the management of long term conditions such as diabetes and asthma.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



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

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

Good



# Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The surgery was open until late on four evenings a week and on Saturday mornings through to April for GP consultations to meet help meet the needs of the working age population. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

## People whose circumstances may make them vulnerable

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for patients in this group

Good



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

The practice is rated as good for the care of people experiencing poor mental health . The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health and had worked to put together a document for these patients that accompanied them to hospital to ensure healthcare staff had an insight of the individual and their needs and preferences . Staff had received training on how to care for people with mental health needs and dementia.

Good



# Summary of findings

## What people who use the service say

During the inspection we spoke with patients and carers that used the practice and met with the chair of the patient reference group (PRG) The PRG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We spoke with 15 patients during our visit. We reviewed 24 comments cards that had been provided by CQC on which patients could record their views. All the patients we spoke with, and 23 of the patients who had completed comments cards and letters, emphasised the caring attitude of the staff and quality of care. They told us that the care and treatment they received was good and that they felt fully informed as to their treatment options. Their confidentiality and dignity was respected. One respondent had made negative comments that the waiting time to see their own GP was too long and there had been a high 'turnover' of GPs.

### National GP Patient Survey

The GP Patient Survey results (an independent survey run by Ipsos MORI on behalf of NHS England) published in January 2015 showed the following:

- 91% found it easy to get through to this surgery by phone -CCG average: 77% , national average: 73%
- 92% found the receptionists at this surgery helpful -CCG average: 89%, national average: 87%
- 49% with a preferred GP usually got to see or speak to that GP -CCG average: 67%, national average: 60%
- 88% said the last appointment they got was convenient-CCG average: 92%, national average: 92%
- 83% described their experience of making an appointment as good -CCG average:78% , national average: 73%
- 69% usually waited 15 minutes or less after their appointment time to be seen- CCG average:70%, national average: 65%
- 97% said the last nurse they saw or spoke to was good at listening to them CCG average 90%
- 94% of respondents found the receptionists at the surgery helpful-CCG average: 90%

We looked at a patient survey carried out by the practice in December 2014, two months prior to our inspection, and saw that of 360 respondents, 91% had said the GPs were good or very good at involving them in decisions about their healthcare and 96% said GPs were good or very good at listening to patients

# Munro Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two GPs, a practice manager and an expert by experience who is a person who has experience of using this type of service.

## Background to Munro Medical Centre

Munro Medical Centre, is located in Spalding, a south Lincolnshire market town with a population of approximately 29,000 and covering an area of some 100 square miles. The practice provides GP services under a Personal Medical Services (PMS) contract to 19,705 patients in the town and surrounding area, half of the population. The principle employment of people living in the locality are horticulture, food processing and logistics.

The practice was established in 1919 and moved to its current purpose built premises in 1996. The building has been further extended and improved to meet the needs of patients. The practice has a branch surgery in the nearby village of Pinchbeck that was not visited during the course of the inspection.

The practice has eight GPs, eight nurses and five health care assistants. They are supported by a team of administrators, receptionists, dispensers, data inputters and managerial staff. In all the staff total 72.

It is a GP training practice.

The patient population has a relatively low deprivation score of 13.4 compared with a national average of 21.6, although within the practice population there was clear

evidence of deprivation, particularly associated with migrant workers and their families. The age profile of the practice showed that 9% of the patient population was aged 75 or over. 16% of the patient list were from Eastern European.

The practice is located over two floors, though all areas accessed by patients were located on the ground floor.

The surgery was open from 8 am until 6.30 pm Monday to Friday. On Wednesday the surgery closed from 12.30 to 1.30 pm for staff training. The surgery was open late on four evenings a week and was open on Saturday mornings until the end of February as a result of finance obtained through the winter funding initiative.

On a typical day the practice receives up to 1,000 telephone calls, offered 400 face to face consultations 200 telephone consultations and a dozen home visits.

It is a dispensing practice, providing dispensing services to 3,000 eligible patients.

The practice lies within the NHS South Lincolnshire Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust.

The practice had not previously been inspected by the Care Quality Commission.



# Detailed findings

## Why we carried out this inspection

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

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

## How we carried out this inspection

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

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

- Is it well-led?

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 February 2015. During our visit we spoke with a range of staff and spoke with 15 patients who used the service. We talked with patients and their carers and family members. We reviewed 24 comment cards and letters where patients and members of the public shared their views and experiences of the service. We also received the views of a healthcare professional who works with the practice.

In advance of our inspection we talked with the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We also reviewed information we had received from Healthwatch, NHS Choices and other publically accessible information.

# Are services safe?

## Our findings

Overall the practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

### **The practice was able to provide evidence of a good track record for safety;**

The practice had systems for reporting, recording and monitoring significant events, incidents and accidents. Records showed the practice had managed incidents consistently over time and so could evidence a safe track record.

### **Lessons were learned and improvements were made when things went wrong;**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events was a standing item on the practice meeting agenda. When things went wrong thorough and robust investigations and significant event or incident analysis was carried out. Relevant staff and patients who used the practice were involved in the investigation.

There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example we saw how one significant event had been identified as a result of a receptionist being unaware of the that young people could under some circumstances been seen without the consent or presence of a parent. We saw documented evidence that learning had been derived for this event leading to further training for reception staff in Gillick competency. (The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). We saw that that this issue had been subsequently discussed at a practice meeting. We also saw an example of where a patient with the same name as another patient had been inadvertently given a

prescription not intended for them. We saw that the matter had been fully investigated and processes put in place to prevent any re-occurrence. The matter had been discussed and recorded at a practice meeting.

Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Written records and analysis of incidents were detailed and had been discussed at practice meetings.

### **There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse;**

Patient safety alerts were received into the practice electronically and distributed to every member of the practice team by email.

Child protection and vulnerable adult policies provided staff with information about identifying, reporting and dealing with suspected abuse that was reported or witnessed. Clinical staff had received safeguarding training at an appropriate level. Staff we spoke with could all name the safeguarding lead at the practice. These staff could describe how they would access information and report abuse. The key aspects of the practice whistleblowing policy were understood by the members of staff we spoke with about it.

The practice had a register for vulnerable children, and systems to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

Appropriate checks and procedures were in place to make sure refrigerated medicines were stored at the correct temperature. Arrangements were in place to ensure the efficacy of medicines and equipment required in a medical emergency.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Expired and unwanted medicines were disposed of in line with waste regulations.

There were safeguards to ensure prescriptions were checked, and a process to regularly review patients' repeat prescriptions in accordance with the latest guidelines to ensure they were still appropriate and necessary. The practice had a system in place to assess the quality of the

## Are services safe?

dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

We observed all areas of the practice to be very clean, tidy and well maintained, and staff followed appropriate infection control procedures to maintain this standard. A nurse was the nominated lead for infection prevention and control. They had undertaken some additional training to assist in this role. We saw there were cleaning schedules in place and cleaning records were kept.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

All equipment used for invasive procedures was disposable, stored correctly and in date. Staff had sufficient access to protective equipment such as gloves and aprons to reduce risk of infection.

Calibration checks for medical equipment and medicine fridges had been completed. Fire extinguishers, fire alarms, and portable appliances had all been recently tested.

**Risks to individual patients who used services were assessed and their safety was monitored and maintained for example;**

There were sufficient numbers of staff with appropriate skills to keep people safe, and rota systems and forward planning to maintain this. These took into account changes in demand, annual leave and sickness. Records showed that appropriate checks were undertaken prior to employing staff, such as identification checks and with the Disclosure and Barring Service to ensure their suitability to work in a GP practice.

The practice had assessed risks to those using or working at the practice and kept these under review. Patients with a change in their condition were reviewed appropriately. Patients with an emergency or sudden deterioration in their condition could be referred to a GP for quick assessment.

**Potential risks to the practice were anticipated and planned for in advance for example;**

There were emergency procedures and equipment in place to keep people safe. Staff had received training in basic life support, and a defibrillator was available. Staff could describe the roles of accountability in the practice and what actions they needed to take in an emergency. Equipment to be used in the case of emergency was checked and found to be fit for purpose and checked regularly.

A business continuity plan was in place to inform staff of the action to take in circumstances such as the loss of loss of data, IT failure, flooding, fire or loss of utilities.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

We saw that the practice operated a system whereby each GP had their own patient list. GPs told us that this helped to ensure continuity of care.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice carried out clinical audits, for example the use of non-steroidal anti-inflammatory drugs and antibiotics. The audits were detailed, complete and subject to a second cycle of audit.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for

GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice exceeded the national averages in every clinical domain indicator group.

We saw that the practice achieved highly in caring for patients with long term conditions. For example we saw there was a high rate of retinal screening of 97% compared with a national average of 90% and emergency admission rates for diabetic patients was almost halved at 0.76% compared to 1.41% nationally. For patients with asthma the emergency admission rate was 0.77% compared to a national average of 1.87%.

Cervical screening of eligible patients had a high uptake with 84.4% having been completed in the year to date. The practice was a participant in the 'Pink Pants' campaign, aimed at increasing awareness and promoting cervical screening.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. For example we saw how the senior nurse reviewed nurses clinical performance on a weekly basis.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

### Effective staffing

# Are services effective?

## (for example, treatment is effective)

Practice staffing included medical, nursing, managerial and administrative staff.

Checks were made on qualifications and professional registration as part of the recruitment process. Staff were given an induction and further role specific training when they started. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with several of them having additional special interests in differing areas of medicine. 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 undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

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

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles such as seeing patients with long-term conditions like diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

We saw that where poor performance had been identified appropriate action had been taken and senior staff we spoke with told us how it had been managed with the staff concerned.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

### Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For patients with dementia the practice had been involved in the development of a document called 'Who am I' which was used to convey details of people suffering from dementia to staff in hospitals in the event that they were admitted.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record SystmOne to coordinate, document and manage patients' care. Staff were trained to use the system, and commented positively about its ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

### Consent to care and treatment

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if

# Are services effective?

(for example, treatment is effective)

changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

## Health promotion and prevention

It was practice policy to ask all new patients registering with the practice to complete a questionnaire regarding

their health. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic flu immunisations to at risk and eligible patients. The practice also offered a range of services such as contraceptive advice, chlamydia screening, smoking cessation and midwife led antenatal clinics.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance .

The practice offered NHS Health Checks to all its patients aged 40 to 74 years.

The patient waiting area contained a wealth of health promotion and information leaflets.



# Are services caring?

## Our findings

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Staff helped people and those close to them to cope emotionally with their care and treatment.

### **The staff at the practice treated people with kindness, dignity, respect and compassion when they received care and treatment.**

We spoke with 15 patients during the inspection, and collected 24 CQC comment cards. Patients indicated they were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable.

Data from the National Patient survey showed that 87% said the last GP they saw or spoke to was good at treating them with care and concern compared with a CCG average of 84% and national average of 85%.

Patients we spoke to during the inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

consultations to make an informed decision about their treatment options. In the latest survey carried out by the practice, 91% had said the GPs were good or very good at involving them in decisions about their healthcare and 96% said GPs were good or very good at listening to patients.

Consultations and treatments were carried out in private rooms, with disposable curtains around treatment couches to maintain patients' privacy and dignity. Patients could request trained chaperones if they wished and signage was evident in reception and consultation rooms to that effect.

There was a translation service available for those whose first language was not English. Patient information leaflets were available in different languages. The patient self check-in screen could display information in a number of languages.

### **People who use services and those who are close to them are involved as partners in their care.**

Patients said they were given good emotional support by the doctors, and were supported to access support services to help them manage their treatment and care. GP's referred people to bereavement counselling services where necessary.

The practice kept registers of groups who may need extra support, such as those receiving palliative care and their carers, and patients with mental health issues.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

Overall the practice is rated as good for providing responsive services. The needs of different people were taken into account when planning and delivering services. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. Patients could access the right care at the right time. Access to appointments and services were managed to take account of patient's needs, including those with urgent needs.

### **Services were planned and delivered to meet the needs of people.**

For instance the practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions.

Longer appointments could be made available where required. The practice had a robust system to follow up on those patients who did not attend for screening or long term condition clinics.

The surgery reception area was spacious and comfortable with ample seating. There was sufficient room for pushchairs, wheelchairs and mobility scooters to safely negotiate through the building. The building accommodated the needs of people with disabilities, with level thresholds. All treatment/consulting rooms used by patients of the practice and patient toilets were on the ground floor. Car parking spaces were available. There was a practice information leaflet available in reception and on the practice website. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

### **People could access care and treatment in a timely way.**

Information about how to arrange appointments, opening times and closures was on the practice website or patient information leaflet. There were arrangements in place to ensure patients received medical assistance when the practice was closed.

The surgery was open from 8 am until 6.30 pm Monday to Friday. On Wednesday the surgery closed from 12.30 to 1.30

pm for staff training. The surgery was open late on four evenings a week and was open on Saturday mornings until the end of February as a result of finance obtained through the winter funding initiative.

Patients could view their summary care record and order repeat prescriptions online.

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

People's concerns and complaints were listened and responded to and used to improve the quality of care.

The practice had a system in place for handling complaints and concerns. There was a designated person who handled all complaints in the practice. Information on how to complain was in the patient information leaflet and on the practice website. Information was also displayed in the patient waiting area.

We looked at a summary of complaints made during 2014 and 2015, and could see that these had been responded to with a full explanation and apology.

The practice summarised and discussed complaints with staff at practice meetings, and we saw the minutes of the meetings where they had been discussed.

### **Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services, for example the high number of migrant workers originating from eastern Europe and had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. We saw that the practice had a cultural and religious policy which instructed staff in how they could ensure that individuals religious beliefs could be upheld, for example it stated that staff were permitted to wear religious head dress such as turbans and headscarves.

The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. There was lift access to the first floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and



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

allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

# Are services well-led?

Good 

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

## Our findings

The practice is rated as good for being well-led. The practice had a clear vision and values to improve the health and well-being of patients and provide good quality care. We found the GP partners we spoke with on the day of our inspection to be dynamic, dedicated and committed to providing the best possible service and clinical outcomes to patients. Their enthusiasm was shared by other members of staff we spoke with.

The practice had an overarching governance ethos which incorporated key governance areas. Governance systems in the practice were underpinned by:

- A clear staffing structure and a staff awareness of roles and responsibilities. Staff were clear on their roles and responsibilities, and felt supported by doctors and managers in these. There was a whistleblowing policy which was available to all staff and staff we spoke with were aware of it.
- Practice specific policies that were implemented and that all staff could access.
- Poor staff performance that may affect patient care was dealt with efficiently and rigorously.
- A system of reporting incidents without fear of recrimination and whereby learning from outcomes of analysis of incidents actively took place. Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service and good standard of care. Staff described the culture at the practice as open and honest and said they felt confident giving feedback. Staff told us they generally felt involved and engaged in the practice to improve outcomes for both staff and patients.
- A system of continuous audit cycles which demonstrated an improvement on patients' welfare.
- Clear methods of communication that involved the whole staff team to disseminate best practice guidelines and other information.
- Proactively gaining patients feedback and engaging patients in the delivery of the service and acting on any concerns raised by both patients and staff. The practice were aware that they had received comparatively low scores in the GP Patient Survey carried out between July

2013 and March 2014 in areas that related to interaction of patients with GPs and nurses. We were told by the senior partner that these results were primarily attributable to some staffing issues that had since been resolved. In response the practice had carried its own surveys. In December 2014, two months prior to our inspection, of 360 respondents, 91% had said the GPs were good or very good at involving them in decisions about their healthcare and 94% said GPs were good or very good at listening to patients. A similar survey was carried out that asked the same questions in respect of the practice nurses in January 2015. 400 patients completed the survey of who 88% said nursing staff were good or very good at involving them in decisions and 96% said they were good or very good at listening to patients.

The practice had an active patient reference group (PRG) that had 123 members and an active committee consisting of 16 people. A PRG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care. We spoke with the Chair of the group who told us that the group was as active member of the Public and Patient Involvement Committee run by the CCG that brought together PRG's in the CCG area. Together they had worked on a document called 'Who am I' which was used to convey details of people suffering from dementia to staff in hospitals in the event that they were admitted.

The Chair told us how the work of the PRG had been effective in dispensing with the 0844 telephone number previously used by the practice as result of patient representations about the costs incurred. They also told us how they had worked with the practice to have automatically opening doors fitted to the reception area for the benefit of people using wheelchairs.

The GPs were all involved in revalidation, appraisal schemes and continuing professional development. One member of staff told us how they were being supported to gain additional qualifications at the University to enhance their skills in dealing with diabetic patients.

The GPs had learnt from incidents and complaints and recognised the need to address future challenges. This included succession planning and future developments working with the local commissioning group.

# Are services well-led?

Good 

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

The practice was a teaching practice and one GP partner was a GP Trainer. The practice supported one Foundation Year 2 doctor.

There were systems in place to monitor quality and identify risk. Data from the Quality and Outcomes Framework (QOF) showed the practice was performing at or above national standards. The practice regularly reviewed its results and how to improve. Total clinical QOF points for the last year for which they were available showed the practice achieved 100% 2.4% above the CCG average and 6.5% above the national average.

From our discussions with staff we found that they looked to continuously improve the service being offered, and valued the learning culture.

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Appraisals took place where staff could identify learning objectives and training needs. Appraisals were carried out by departmental heads and staff we spoke with and records we saw confirmed this to be the case. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings.

We saw from minutes that team meetings were held regularly, and were led by heads of departments, for example receptionists meetings, dispensary and clinical meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Monthly practice meetings were held that were attended by GPs and heads of departments.

The practice had given every member of staff a copy of the staff handbook in compact disc format and it was also available on the practice computer system. The handbook contained a number of policies to support staff including a whistleblowing policy, a 'being open' policy to encourage staff to report when things went wrong and an equal opportunities policy.