Dr O S Singh & Partners

Quality Report

Lordswood Community Healthy Living Centre
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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 an announced comprehensive inspection at Dr O S Singh & Partners on 27 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well led services. It was also good for providing services to older people, people with long-term conditions, families, children and young people, as well as 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). The practice required improvement for providing safe services and the concerns which led to this rating applied to all population groups.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to some of the medicines kept at the practice.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice was clean and there were systems to help ensure standards of hygiene were maintained.

Summary of findings

- 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.

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

Importantly, the provider must:

- review the arrangements for the safe management of medicines kept at the practice - including how vaccines are stored, and the process for monitoring and checking expiry dates for all medicines, injections and medical equipment
- review the system used to monitor and record the pre-printed prescription pads issued to GPs, in accordance with national guidance.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services, as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. There were enough staff to keep people safe. However, there were some concerns in relation to the management of medicines kept at the practice, including how they were checked and stored, as well as the system used for the security of prescription pads.

Are services effective?

Good

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 The National Institute for Health and Care Excellence (NICE) 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 the practice was able to demonstrate that appraisals had been completed for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others in some aspects of care. Patients we spoke with 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 available services was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of the local patient population and engaged with their local NHS England area team and clinical commissioning group (CCG) to plan service requirements. Patients said they were able to make an appointment with a named GP, and that urgent appointments were 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, easy to understand and the practice responded to

Summary of findings

issues raised. Learning from comments and complaints was shared with staff and changes were made. The practice had developed an improvement plan based on the findings of patient survey results and feedback received.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a documented mission statement and practice charter. Staff were clear about the practice aims, objectives and values and their responsibilities in relation to these. There was a clear leadership structure, staff knew who to go to with issues and felt supported by management.

The practice had policies and procedures to govern activity and regular practice meetings had taken place. There were systems to monitor and improve quality and to monitor identified risks. The practice did not have an active patient participation group, although comments and feedback from staff and patients were acted upon to make improvements to the services provided. Staff had received inductions, regular performance appraisals and attended staff meetings and events.

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

Good

The practice is rated as good for the care of older people. Older people received care and treatment relevant to their age group, including blood tests and blood pressure monitoring. They received routine annual health checks to review their medicines and general well-being.

The practice offered proactive, personalised care to meet the needs of older people and was responsive in offering home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had been allocated a named GP who was responsible for their care.

Annual influenza vaccinations were routinely offered to older people to help protect them against the virus and associated illness. The practice held regular meetings with community based specialist teams to share information and provide effective treatments and support to older people identified with complex conditions, such as dementia and conditions associated with end of life care. The practice had a lead GP with a special interest in palliative care who provided overall case management, including guidance for staff and support for carers of older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice offered specialist clinics and appointments for conditions such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes.

Longer appointments and home visits were available for patients with long-term conditions and annual reviews were arranged to check their health and medication needs were being met. The practice was proactive in undertaking regular prescribing reviews for patients with long term conditions who were prescribed multiple medicines and had a lead GP with a special interest in medicine management who worked closely with the area medicines management team.

For those patients with the most complex needs the named GP worked with relevant health care professionals to deliver a multidisciplinary package of care. Community nurses and staff from the community palliative care team attended regular meetings with the GPs and nursing staff, where the needs of patients with chronic and terminal illnesses were discussed.

Summary of findings

Influenza vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Expectant mothers were supported by the midwife linked to the practice and mother and baby clinics were offered for post-natal care as well as baby checks with the GP. There were systems to identify children who may be at risk and safeguarding procedures to help ensure concerns were followed up.

Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice prioritised appointment requests for children and there were emergency processes and referrals made for children who had a sudden deterioration in health.

The practice offered information about sexual health and screening for sexually transmitted diseases. Follow-up support was offered where necessary, and a lead GP within the practice had a special interest in women's health and offered contraceptive advice and pre-conception counselling.

Working age people (including those recently retired and students)

Good

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 patient population, those recently retired and students had been identified and the practice had adjusted the services it provided to help ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group. For example, NHS health checks were offered to patients between the ages of 40 and 74 and the practice used these checks to promote healthy lifestyles and identify early risk factors that required follow-up.

The practice offered advice and support to patients returning to work following sick leave, including advice about phased return options and 'fitness to work' advice and notifications.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was responsive in providing care in patient's homes who found it difficult to attend the practice. The practice carried out annual health checks

and offered longer appointments if required. For example, for patients with a learning disability and their carers. The practice worked with multi-disciplinary teams in the case management of vulnerable people and offered information about various support groups and voluntary organisations, for example, local alcohol support services.

Practice staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of working hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health. The practice had procedures for identifying patients who had mental health needs. Regular checks were offered and follow-up contact was made where patients had not attended for appointments. The practice staff had received training on how to respond and prioritise appointments for patients with mental health needs and adopted a flexible approach in the support it offered. This included offering same day appointments and referral to other service providers for on-going support where required, including crisis support.

The practice worked with multi-disciplinary teams and community specialists in providing support to patients with mental health needs and those with dementia, for example, the community mental health team and mental health assessment specialists.

Summary of findings

What people who use the service say

We spoke with nine patients and reviewed 19 comment cards completed by patients prior to our inspection. Patients we spoke with during our inspection were very positive about the services they received from the practice. They were complimentary about the staff, and said they were caring, supportive and helpful. One patient said they had found the reception staff quite rude on occasions in the past, but there had been definite improvements in the last year and staff were very good.

Some patients commented that they sometimes had difficulties getting through to the practice on the telephone in the mornings to get an appointment. However, most patients told us this was not a problem and the appointments system worked well for them.

There were many positive comments from patients who had completed comment cards. They expressed a high level of satisfaction with the service they had received from the practice and there were many very positive comments about the staff.

Areas for improvement

Action the service MUST take to improve

- review the arrangements for the safe management of medicines kept at the practice - including how vaccines are stored, and the process for monitoring and checking expiry dates for all medicines, including injectable medicines and medical equipment
- review the system used to monitor and record the pre-printed prescription pads issued to GPs, in accordance with national guidance.

Dr O S Singh & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, and a practice manager specialist advisor.

Background to Dr O S Singh & Partners

Dr O S Singh & Partners provides medical care Monday to Friday from 8.30am to 6pm each week day and operates extended opening hours until 8pm on Monday evenings. The practice is situated in the Lordswood area of Chatham in Kent and provides a service to approximately 8,000 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing team. There are a range of patient population groups that use the practice and the practice holds a General Medical Services (GMS) contract. The practice does not provide out of hours services to its patients and information is available to patients about how to contact the local out of hours services when the practice is closed.

The practice has one male and one female GP partner, two long-term male locum GPs, two female practice nurses, and a female health care assistant. The practice has a number of administration / reception and secretarial staff as well as a practice manager.

The practice has more patients in the younger age population groups than the local and national averages. The number of patients of a working age registered with the practice are in line with the local and national averages, although there are a lower number of patients over the age of 65 when compared to the local and national averages. The number of patients recognised as suffering deprivation is lower than the local and national averages.

Services are delivered from:

Lordswood Community Healthy Living Centre

Sultan Road

Lordswood

Chatham

Kent

ME5 8TJ

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 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew, including the NHS England area team, the local clinical commissioning group (CCG) and the local Healthwatch.

We carried out an announced visit on the 27 November 2014. During our visit we spoke with three GPs, one nurse, five reception / administration staff and the practice manager. We spoke with nine patients who used the service. We placed comment cards in the surgery reception so that patients could share their views and experiences of the service before and during the inspection visit.

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).

Requires improvement

Are services safe?

Our findings

Safe track record

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

We reviewed safety records and incident reports for the previous two years and saw minutes of meetings where these were discussed. This demonstrated that the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last five years. Significant events were discussed at general practice meetings as well as weekly clinical meetings and there was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including reception and administrative staff, knew how to raise an issue for consideration at the meetings and said they felt encouraged to do so.

Staff completed incident forms on the practice computer and sent them to the practice manager, who managed and monitored incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner and that actions were taken as a result. For example, an incident concerning a missing prescription had resulted in a review of the system used to record and log prescriptions collected by the pharmacy. Where patients had been affected by something that had gone wrong, they were given an apology 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. They also told us alerts were discussed at practice meetings to help ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

There were effective systems and processes to manage the practice safely, including arrangements for safeguarding vulnerable adults and children who used services. The practice had a policy for safeguarding both children and vulnerable adults and this clearly set out the procedures for staff guidance and contact information for referring concerns to external authorities. The policy reflected the requirements of the NHS safeguarding protocol and included the contact details of the named lead for safeguarding within the NHS and social services area teams.

Staff told us that a GP partner was the designated lead in overseeing safeguarding matters. GPs, nurses and administrative staff we spoke with were knowledgeable in 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 safeguarding concerns and how to contact the relevant agencies in working hours and out of hours.

Staff told us they had received training in safeguarding vulnerable adults and children and we saw records that confirmed this. The safeguarding lead GP had the necessary training (level three) to fulfil their role in managing safeguarding issues and concerns within the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans and older patients who lived in vulnerable circumstances. GPs told us they liaised regularly with social services to share information when concerns were identified within the practice. For example, staff had alerted social services regarding a vulnerable older patient with mental health issues, who appeared to be suffering self-neglect.

The practice had a chaperone policy, which set out the arrangements for those patients who wished to have a chaperone (a chaperone is a person who acts as a

safeguard and witness for a patient and health care professional during a medical examination or procedure). Information about the chaperone policy was clearly displayed where patients' could see it and the staff we spoke with confirmed chaperones were arranged for those patients who requested one.

Medicines management

We checked medicines stored in the treatment rooms, as well as medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy to help ensure that medicines were kept at the required temperatures, which described the action to take in the event of a power failure and records confirmed that refrigerator temperatures were routinely checked on a daily basis. However, the medicine refrigerator had been over-stocked, with vaccine boxes touching the internal sides. The practice had a second medicine refrigerator and staff explained that this was not in use as the lock had broken.

There were processes to check that medicines were within their expiry date and suitable for use. However, when we checked the vaccines kept in the practice, we found a vaccine, tubing and some syringes that were outside their safe usable date.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of the directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had a system to maintain the security of blank prescription pads used in the computer printers and a risk assessment had been undertaken. However, there was not a robust system to monitor and record the pre-printed prescription pads issued to GPs, in accordance with national guidance, to help ensure these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The practice was clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow. For example, hand hygiene, management of sharps, decontamination of equipment and clinical / hazardous waste management. A member of staff was the infection control lead for the practice. They demonstrated a clear understanding of their role and responsibilities in relation to infection prevention and control. Infection control audits had been undertaken and identified actions were monitored and recorded for discussion in staff meetings.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. Guidance was displayed in each treatment room for staff to follow in relation to hand washing technique and needle stick injuries. There were cleaning schedules in place and cleaning records were kept.

Regular checks for the detection and management of legionella (a germ found in the environment which can contaminate water systems in buildings) had been carried out at the practice and records confirmed this.

We spoke with staff who told us they had received training in infection control and the training records confirmed this. Staff were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control.

Equipment

Clinical equipment was appropriately checked to help promote the safety of staff, patients and visitors. Staff told us that equipment used in the practice was routinely checked. They said they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments and that all equipment was tested and maintained regularly and records confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The practice had a policy setting out the arrangements for the maintenance and calibration of medical equipment and records confirmed that this had been followed. For example, regular checks had been carried out on equipment used to measure blood pressure and calibration had been undertaken of the weighing scales.

Requires improvement

Are services safe?

Staffing and recruitment

Records demonstrated that appropriate recruitment checks had been undertaken prior to the employment of staff. 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 set out the standards it followed when recruiting staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system for the different staffing groups to help ensure that enough staff were on duty. There were also arrangements for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff to keep patients safe. The practice had a staffing policy that reflected the minimum staffing levels for the practice and the GPs described how this was maintained, including the arrangements for GP locum cover.

Monitoring safety and responding to risk

The practice had developed systems to respond to identified risks. For example, staff we spoke with described the procedure for dealing with safety alerts from outside agencies to keep the practice up-to-date with failures in equipment, processes, procedures and substances.

The practice had systems to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building and the environment, for example, in relation to fire safety checks. The practice also had a health and safety policy and information was displayed for staff guidance.

Identified risks were included in a central risk folder. Each risk was assessed and actions recorded to reduce and manage the risk. For example, a risk assessment had been completed to identify a safe process for the collection of signed prescriptions by external pharmacies.

The practice had procedures to manage individual risks to patients in relation to deteriorating health and staff gave examples of how they monitored changing risks to different patient groups. For example, the electronic records system identified patients experiencing poor mental health, who may have required urgent support from community mental health specialists, such as the duty psychiatrist, or an urgent appointment with the GP. Appointments were managed flexibly in these circumstances to help ensure patients received urgent support when required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to medical oxygen. All staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a recent medical emergency, learned from this appropriately and implemented a revised protocol to provide guidance for staff in how to respond.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. The emergency medicines we checked were within their expiry dates and suitable for use.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, severe bad weather that caused staff shortages, interruption to utilities, or unavailability of the premises. The document also contained relevant contact details for staff to refer to, for example, contact details of a heating company to contact if the heating system failed.

The practice had a fire risk assessment and an action plan to maintain fire safety. Records showed that staff were up to date with fire training and that they undertook regular fire drills. There was also a named fire warden for the practice who took lead responsibility for fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New guidelines were discussed and shared amongst the GPs and nursing staff within the practice.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. Guidance templates were used and embedded into the computer system to help ensure GPs and nurses were using up-to-date assessment tools. Staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. GPs had special interest in clinical areas, such as dermatology, women's health, palliative care and prescribing. Administrative staff had specific roles and areas of responsibility, including summarising medical records, data input and scanning, repeat prescriptions, scheduling clinical reviews and patient recall management.

Registers were kept to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions including dementia, asthma, heart disease, and diabetes. The electronic records system contained indicators to alert GPs and nursing staff to specific patient needs and any follow-up actions required, for example, medicine and treatment reviews. Registers were kept under review and meeting minutes demonstrated that information was shared and discussed regarding the health care needs of specific patients, as well as any additional risk factors that may need to be identified on the system. For example, for patients over the age of 75 and those at risk of unplanned care admissions to hospital, patients had been identified for same day GP contact, to help ensure they received appropriate care interventions where required. All patients over the age of 75 had a named GP who was responsible for their care and treatment.

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. Quality and Outcomes Framework (QOF) data indicated that multidisciplinary review meetings were held at least every three months to discuss all patients on the register. QOF is a national performance measurement tool used by GP practices to monitor outcomes for patients.

The practice collected information for the QOF that was reviewed, shared and discussed at clinical meetings amongst relevant staff. The practice measured on-going performance data by comparison to other practices in the area and identified where improvements were required or had been achieved. For example, the practice had identified that the prevalence of patients diagnosed with diabetes was low by comparison and had therefore discussed ways of ensuring that patients were appropriately diagnosed. Other available QOF data showed that the practice was performing at or above the national average in most clinical areas. For example, 99% of patients diagnosed with diabetes had received an influenza vaccination, compared to the national average of 93%.

The practice had a system for completing clinical audits and we saw two clinical audits that had been undertaken in the last year. The practice was able to demonstrate that changes had been made since the initial audit. For example, a review of the process used for repeat prescribing of a specific medicine and an audit to review the monitoring and treatment of patients with mental health needs. Although other clinical audits had been undertaken, such as an audit to review the outcomes for patients who received injections for joint pain, these had not been reviewed to assess the results.

Effective staffing

Practice staff included GPs, nurses, managerial and administrative staff. Records showed that all staff were up to date with attending mandatory courses such as annual basic life support. GPs and nurses had also completed specialist clinical training appropriate to their roles. For example, diabetes, asthma, family planning and updates in childhood immunisations, vaccinations and cervical cytology.

We were told by staff that they received annual appraisals and informal supervision. All the staff we spoke with felt they received the on-going support, training and

Good

Are services effective?

(for example, treatment is effective)

development they required to enable them to perform their roles effectively. Records confirmed annual appraisals had been undertaken and these identified training and development needs and agreed actions were documented for the coming year. The practice was proactive in providing training for relevant courses, for example, support to undertake a diploma in health and social care. The practice closed for training one afternoon each month, to provide in-house opportunities for staff learning and development.

All GPs were up to date with their annual continuing professional development requirements and all had either 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Working with colleagues and other services

The practice had well established processes for multi-disciplinary working with other health care professionals and partner agencies. GPs and nurses told us these processes helped to ensure that links remained effective with community and specialist nurses, to promote patient care, welfare and safety. For example, GPs and nurses attended quarterly multidisciplinary meetings that included community nurses who specialised in palliative care and had specialist knowledge in long-term and complex conditions. The practice had systems to help ensure that effective communication was in place to share information, so that patient's records were appropriately updated.

Multi-disciplinary meetings were also held to review and discuss the needs of patients over the age of 75, and included the involvement of an advanced assessment nurse, who held a caseload of older patients referred by the practice. These patients had been identified at higher risk of deteriorating health and required additional community support to help avoid unplanned hospital admissions. Other patients, including those in vulnerable circumstances, had their treatments reviewed and discussed on a multi-disciplinary basis. For example, patients who had a learning disability were referred and supported by the community learning disability team. Patients experiencing poor mental health were reviewed by the community mental health nurse specialist, who attended practice meetings when required.

The practice 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 GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

Information sharing

Staff told us that there were effective systems to help ensure that patient information was shared with other service providers and recognised protocols were followed. For example, there was a system to monitor patients' transition in relation to unplanned / emergency admissions to hospital. A referral system was used to liaise with the community nurses and other health care professionals, including the' out of hours' service. The practice used the 'Choose and Book' referral 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. An electronic patient record system was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system and told us the system worked well. The system enabled scanned paper communications, such as those from hospital, to be saved in the patients' electronic records.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and provided guidance for staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent was recorded.

Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have the capacity to make a decision. Mental capacity assessments were carried out by the GPs and recorded on individual patient records. The records indicated whether a carer or advocate was available to attend appointments

Good

Are services effective?

(for example, treatment is effective)

with patients who required additional support and there was a system for acquiring third party consent where a carer or advocate was registered to support patients in this way.

Records showed that Mental Capacity Act 2005 training had been undertaken by one of the GPs in the practice who cascaded the training to other staff in the practice. 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). Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff.

Health promotion and prevention

Staff told us about the process for informing patients that needed to come back to the practice for further care or treatment or to check why they had missed an appointment. For example, the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients told us they were contacted by the practice to attend routine checks and follow-up appointments regarding test results.

There was a range of information leaflets and posters in the waiting area for patients, informing them about the practice and promoting healthy lifestyles, for example, smoking cessation and weight loss programmes. Patients were encouraged to make use of free NHS health checks that were available to those between the ages of 40 and 74 years and to use self-monitoring weighing facilities at the practice. Information about how to access other health care services was also displayed to help patients access the services they needed to promote healthy lifestyles, for example, exercise groups and stress management.

The practice offered and promoted a range of health monitoring checks for patients to attend on a regular basis. For example, cervical smear screening, sexual health screening and general health checks including weight and blood pressure monitoring. We spoke with nursing staff who conducted various clinics for long-term conditions and they described how they explained the benefits of healthy lifestyle choices to patients with long-term conditions such as diabetes, asthma, epilepsy and coronary heart disease. All new patients who registered with the practice were offered a consultation with one of the nurses to assess their health care needs and identify any concerns or risk factors that were then referred to the GPs.

The practice had systems to identify patients who had increased health risks and were pro-active in offering additional preventative services. For example, vaccination clinics were promoted and held at the practice, including a seasonal influenza vaccination for older people. The practice kept a register of patients who had a learning disability and promoted / encouraged annual health checks for these patients.

The practice offered a full range of immunisations for children and travel vaccines. Last year's performance for all childhood immunisations was above average for the clinical commissioning group (CCG) area and there were systems to follow-up non-attenders.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice in relation to patient satisfaction. Information from the national patient survey showed that the practice had been rated below the national average in some areas, although in other areas the practice had been rated above the national average. For example, 95% of patients rated the practice nurses as good or very good in treating them with care and concern, compared with 90% nationally.

Patients completed comment cards to provide us with feedback on the practice. We received 19 completed cards and the majority were positive about the service experienced. Patients commented that the practice offered an excellent service, all staff were helpful, caring and respectful and were professional in their approach. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected, although there were some comments in relation to difficulties in getting through to the practice on the telephone in the mornings. Reception staff were welcoming to patients, were respectful in their manner and showed a willingness to help and support patients with their requests.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consultation 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 had a confidentiality policy, which detailed how staff protected patients' confidentiality and personal information. Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality and the policy had been shared with them. The reception area was designed in a way that meant conversations on the telephone could not be heard by patients in the waiting area. Following the results of the national patient survey, the practice had developed an action plan to consider ways of making improvements. This included a system that had been introduced to allow only one patient at a time to speak at the reception desk to improve privacy and maintain confidentiality.

The practice had arrangements to provide additional support for patients whose circumstances may have made them vulnerable. For example, home visits were arranged for vulnerable patients who might be reluctant or unable to attend the practice.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed there had been a mixed response from patients to questions about their involvement in planning and making decisions in relation to their care. For example, data from the national patient survey showed that 88% of patients said nurses were good or very good in involving them in decisions about their care, compared to 85% nationally. However, 48% of patients said that the GPs were good or very good at involving them in decisions about their care, compared to 81% nationally.

When we spoke with patients, they told us they felt involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. They said GPs and nurses took the time to listen and explained all the treatment options available to them and that they felt included in their consultations. They felt able to ask questions if they had any and were able to change their mind about treatment options if they wanted to. Similarly, when we reviewed the comments cards patients had completed prior to our inspection, patients stated that they were listened to, their questions were answered and that staff responded well to their needs.

There was a range of leaflets and posters in the waiting room that provided patients with information about health care services. For example, information about the practice and the services it offered, the promotion of healthy lifestyle choices and contact details of other services and support that patients may have found useful. Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

Staff were supportive in their manner and approach towards patients. Patients told us staff gave them the support they needed and that they felt able to discuss any concerns or worries they had. The practice offered a separate room where patients could speak privately to a member of staff if they wished and information about this was clearly displayed.

Patient information leaflets, posters and notices were displayed that provided contact details for specialist groups offering emotional and confidential support to patients and carers, for example, a bereavement support group and counselling service. The practice's electronic system alerted GPs if a patient was also a carer and there was a range of information available for carers to help ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs and had systems to maintain the level of service provided. The needs of the practice patient population were understood and there were systems to address identified needs in the way services were delivered. This included regular engagement with the area clinical commissioning group (CCG) to respond to local service needs and to consider improvements to the services provided to patients. The practice had a lead GP who attended regular meetings with the CCG and the practice manager attended CCG forums on a quarterly basis to share information, review updated guidance and consider new initiatives to improve services. Minutes of meetings demonstrated that discussions and actions were agreed to implement service improvements. For example, implementation of the 'friends and family' test. (This is a process for patients to feedback their views and comments to the practice).

The staff we spoke with explained that a range of services were available to support and meet the needs of different patient population groups and that there were systems to refer patients to other services and support if required. For example, referring mothers with babies and young children to the community health visitor and older people to specialist groups who supported people with dementia and associated physical problems. Patients we spoke with told us that they were referred promptly to other services for treatment and test results were available quickly.

The practice did not have a patient participation group (PPG), although an action plan had been developed in response to feedback from the latest national patient survey. This included a review of telephone access to improve how appointments were offered each day. The action plan detailed the installation of an additional telephone line and increasing reception staff, to help improve telephone access at busy times of the day.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, working closely with the community learning disability team to help ensure those patients with a learning disability received appropriate support, including longer appointments with their carers attending if required, as well as an annual assessment of their health care needs.

The premises and services had been adapted to meet the needs of patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had a hearing loop system for patients who had hearing difficulties and interpretation services were available by arrangement for patients who did not speak English.

Access to the service

Appointments were available from 8.30am to 12.30pm and from 3pm to 6pm each week day and the practice operated extended opening hours until 8pm on Monday evenings. This provided flexibility for working patients outside of core working hours. Staff we spoke with were knowledgeable about prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs.

Patients were able to book an appointment by telephone, online or in person. Most of the patients we spoke with said the appointments system worked well for them, although some patients commented that it was sometimes difficult to get through on the telephone in the mornings to make appointments. Patients told us they could have telephone consultations and that the GPs called them back if requested. The GPs we spoke with confirmed that same day telephone consultations were offered to all patients and this was managed via the electronic communication system.

Patients we spoke with and comments we received all expressed confidence that urgent problems or medical emergencies would be dealt with promptly and that staff knew how to prioritise appointments for them. For example, the practice had a system to identify and prioritise patients with mental health needs to help ensure urgent access to a GP appointment and referral to specialist mental health support. The practice had access to a duty psychiatrist and urgent referrals and /or contact was made if required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment. For example, they said that children and pregnant women were given priority if they needed an appointment. Staff described how the GPs decided to support patients in other ways, for example, a telephone consultation or home visit. The practice also offered pre-bookable appointments, online appointment bookings and longer appointments were available for those who needed them, for example, patients with long-term conditions. There was a system for patients to obtain repeat prescriptions and when we spoke with patients, they told us they found the system worked well and their medicines were available when they needed them.

There were arrangements to help ensure patients could access urgent or emergency treatment when the practice was closed. Information about the 'out of hours' service was displayed inside and outside the practice and was also included in the patient information booklet and on the practice website. A telephone message informed patients how to access services if they telephoned the practice when it was closed. Patients we spoke with told us they knew how to obtain urgent treatment when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Its complaints policy was in line with recognised NHS guidance and there was a designated responsible person who handled all complaints in the practice.

Information was available to help patients understand the complaints system. The procedure was included in the practice information booklet, on the practice website and was also displayed in the patient waiting area. We looked at four complaints that had been received in the last year and found that these had been satisfactorily handled and dealt with in a timely way.

A complaints summary report had been produced for the year, to identify any emerging themes or trends and was discussed at practice meetings to review any changes that could be made. For example, an administrative change had been implemented to improve communication and contact with patients in relation to requests for repeat prescriptions when medicine reviews were required before repeat prescriptions were issued.

Patients we spoke with told us they had never had cause to complain but knew there was information available about how and who to complain to, should they wish to make a complaint.

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 mission statement, practice charter and statement of purpose, all of which clearly set out the aims and objectives of the practice, to provide good quality care and treatment for the patients who used its services. The mission statement was displayed in the practice and when speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose of providing good quality care to all patients.

Staff told us they understood their roles and responsibilities in helping to ensure the practice achieved its aims and objectives and felt they contributed to the overall quality of care that patients received.

Governance arrangements

The governance arrangements within the practice included the delegation of lead responsibilities to named GPs, for example, a lead for safeguarding, training, and prescribing. This helped to clarify the role of each GP and provided structure for staff in knowing who to approach for support and clinical guidance. We spoke with ten members of staff and they were all clear about their roles and responsibilities and who to go to if they had any concerns or issues.

Records demonstrated that governance / management meetings were held on a quarterly basis to consider quality, safety and performance within the practice. The items discussed included monitoring of complaints, analysis and review of significant events. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for the practice showed it was performing in line with most national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes. Clinical meetings took place between the practice nursing staff, the GPs and the practice manager on a weekly basis, although not all of these meetings were minuted.

The practice had completed clinical audits, for example, a medicine prescribing audit and an audit to review the monitoring / treatment regimes of patients with mental health needs. Results and findings from the audits were reviewed and discussed amongst the GPs and nursing staff and actions taken to implement changes that improved outcomes for patients.

The practice kept a central risk register that included a range of risk assessments. For example, fire safety, health and safety and the management of signed prescriptions awaiting collection by the pharmacy. These had recently been reviewed and were monitored to manage any changes in the level / type of risk and to follow-up any further actions that were required to minimise risks.

The practice had a number of policies and procedures to govern activity and these were available to staff via any computer within the practice. We looked at twelve of these and they had all been reviewed within the last year. The staff we spoke with told us they were aware of the policies and where to find them for guidance.

Leadership, openness and transparency

The GPs told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. Staff we spoke with told us they felt there was an 'open door' culture, the GPs were approachable, they felt supported and were able to approach the senior staff about any concerns they had. They said there was a good sense of team work within the practice and communication worked well. All staff said they felt their views and opinions were valued. They told us they were positively encouraged to speak openly to all staff members about issues or ways they could improve the services provided to patients.

The practice manager was responsible for the implementation of human resource policies and procedures. We reviewed some of these, for example, recruitment, staffing levels and sickness absence policies. We looked at the electronic staff handbook that was available to all staff, and included sections on the grievance procedure and harassment at work. Staff we spoke with knew where to find these policies if they needed them.

All staff within the practice were involved in meetings. Staff told us they attended meetings and felt that relevant information was shared that kept them up-to-date to support them in their roles. They said a staff 'away day' had taken place within the last year, with a focus on team building and they felt this had benefited all staff within the practice.

Are services well-led?

Good

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

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

The practice had gathered feedback through the national patient survey, as well as comments and complaints received by the practice. Results from the patient survey demonstrated that key areas for improvement had been identified, for example, getting through to the practice on the telephone and making appointments. As a result, the practice had developed an action plan and this included a detailed 'appointments review' that identified specific actions to be completed. For example, a two week trial had been undertaken to 'test' the impact of allocating appointments at different times on different days, according to peak appointment needs. Additional training for reception staff was also planned in the triaging of appointments.

The practice did not have a patient participation group (PPG). However, this had been considered and the benefits acknowledged by the practice management team and we saw that the introduction of a PPG was part of the on-going practice improvement plan.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Records showed that GPs and nursing staff were supported to access on-going learning to improve their skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued professional development. Staff said they had dedicated time set aside for learning and development, for example, the practice had a half-day each month for learning and training opportunities.

Formal appraisals were undertaken for all staff, to monitor and review performance, review personal objectives and to identify training requirements. One member of staff told us they had requested specific training to improve their skills and this had been identified in their development plan for the coming year. There was a system to help ensure that GPs received an annual appraisal and records showed that the GP revalidation process had been implemented at the practice.

The practice had completed reviews of significant events and other incidents and shared them with staff at meetings to help ensure the practice improved outcomes for patients. For example, a recent significant event had identified the need for a revised protocol in dealing with patient emergencies and this had been shared with all staff. The practice management team had also developed an overall improvement plan that identified key areas for improvement and development in the coming year.

The principal GP for the practice was involved in a community educational project that promoted and supported the placement of trainee practice nurses into GP practices to gain experience and practice based knowledge. This initiative was included in the development plan for the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** People who used the services were not protected against the risks associated with the unsafe management of medicines because the provider had not ensured that vaccines were stored safely and checks of injectable medicines and medical equipment had not been routinely undertaken to monitor expiry dates. A secure system was not in place to monitor and record the pre-printed prescription pads issued to GPs. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - the proper and safe management of medicines.