Dr Yannamani's & Dr John's Surgery

Quality Report

Stonydelph Medical Practice
Ellerbeck
Tamworth
Staffordshire
Tel: 01827 987484
Website: no website

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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	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Yannamani's and Dr John's Surgery on 1 December 2015. Overall the practice is rated as Requires Improvement.

Our key findings were as follows:

- Risks to patients were assessed and monitored although resultant outcomes were not always implemented.
- Patients' needs were assessed and care was planned. A patient recall system was in place and all unplanned admissions were reviewed.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with dignity and respect and found the receptionists helpful.
- Patients told us they were happy with the appointment system and urgent appointments were available the same day and normally given when requested.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Importantly, the provider must:

- Maximise the functionality of the computer system in order that the practice can run clinical searches, provide assurance around patient recall systems, consistently code patient groups and produce accurate performance data.
- Ensure that clinical audits in relation to patients' care and treatment complete two cycles to demonstrate improvements in the safety and quality of services provided.
- Operate a system to seek and review patient feedback on the services provided.

In addition the provider should:

Summary of findings

- Update the practice business continuity plan to ensure it contains up to date information.

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?

Good

The practice is rated as good for providing safe services.

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The clinicians we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. However not all clinical staff were aware of all the significant events that had occurred in the practice. There were written risk assessments in place and staff had received basic health and safety training. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded. There were enough staff to keep patients safe. Annual infection control audits were completed and were in line with national guidelines. Clinicians had received training in safeguarding but the practice was unable to evidence that the adult safeguarding training was level three or equivalent.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. GPs told us that they are familiar with current best practice guidance, but when asked to show how to access the National Institute for Health and Care Excellence (NICE), one clinician had difficulty accessing the information. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams to meet the needs of patients. For example, patients receiving end of life care. The practice was below average for Quality Outcomes Framework (QOF) achievement. The overall clinical performance was 60.9% compared to the national average of 94.5% The achievement had dropped by 10% from 2013/4 to 2014/15. The practice stated that the reasons for the below average performance were previously employed staff not managing QOF and high levels of patients not attending their appointments. We saw evidence that the computer coding was not being applied but this was insufficient to demonstrate that effective care was being provided. QOF is a voluntary incentive scheme for GP

Summary of findings

practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect. They said staff were helpful, caring and that the practice team provided patient centred care. Information to help patients understand the services available was easy to understand. We saw that staff were respectful and polite when dealing with patients, and maintained confidentiality. Views of external stakeholders such as other health care professionals were positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients told us they could normally get an urgent appointment on the same day. Patients could book appointments in advance and could normally get to see their preferred GP. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. There was no patient participation group (PPG) but we saw evidence that the practice planned to establish a group. There were online services available to patients but there was no practice website. Online access to summary care records for patients had been planned and training was being organised in order to commence.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. Audits had been done but a second cycle had not been completed to check outcomes. The below average QOF performance data had not been investigated by the practice at the time of our inspection. Staff were aware of the culture and values of the practice and told us patients were at the centre of everything they did. There was no patient group and no action plan written to address patient feedback from other sources, for example, the GP patient survey 2015. Staff told us they felt supported to deliver safe, effective and responsive care. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and systems in place to monitor and improve quality and identify risk. Staff had received inductions, regular performance reviews and attended quarterly staff meetings.

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

Requires improvement

The provider was rated as requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Every patient over the age of 75 years had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and care plans were in place for vulnerable patients. For example, there was a register kept of patients who had been identified as being of high risk of admission. Patients who were palliative had end of life care plans completed and the practice had a lead for palliative care. Regular reviews were held with the community team, district nurses and social services. It was responsive to the needs of older people and offered home visits and longer appointments as required. The practice identified if patients were also carers and offered additional health checks and advice, and information about carer support groups was available in the waiting room.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

We found that the nurse had the knowledge, skills and competency to respond to the needs of patients with a long term condition (LTC) such as diabetes and asthma. The practice nurse had introduced structured reviews in July 2015 for a number of LTCs, for example, diabetes and heart failure. Longer appointments and home visits were available when needed. All of these patients were offered a review to check that their health and medication needs were being met. Written management plans had been developed for patients with LTCs and those at risk of hospital admissions. For those people with the most complex needs, the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children who were at risk. Appointments were available outside of school hours

Summary of findings

and the premises were suitable for children and babies. Same day emergency appointments were available for children. There were screening and vaccination programmes in place and the immunisation rates were in line with the local Clinical Commissioning Group averages. New mothers and babies were offered post-natal checks.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had recently adjusted the appointment system to provide consultations outside core working hours. A range of on-line services were available, including medication requests and booking appointments. Pre-bookable telephone consultations were available. The practice offered all patients aged 40 to 75 years old a health check with the nursing team. The practice offered a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

An interpretation service was in place for non-English speakers. The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability. The practice 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.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

People experiencing poor mental health were offered an annual physical health check. Dementia screening was offered to patients identified in the at risk groups. Advance care planning for patients with dementia was carried out. The practice worked with multi-disciplinary teams in the case management of patients with mental health needs. The practice also worked with the health visiting team to support mothers experiencing post-natal depression. It had told patients about how to access various support groups and voluntary organisations, for example Addiction and Alcoholics Anonymous.

Summary of findings

What people who use the service say

We collected 42 Care Quality Commission (CQC) comment cards. Patients were positive about the service they experienced. Patients said they felt the practice offered good service and staff were helpful, caring and treated them with dignity and respect, for example 24 of the comment cards included positive feedback on the helpfulness and service provided by the reception staff. They said the practice was able to offer appointments when requested. Comment cards highlighted that staff responded compassionately when they needed help, for example, ten of the comment cards collected complimented the practice on providing an urgent appointment when needed.

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages. There were 107 responses and a response rate of 25%.

The results indicated the practice performed significantly above local and national averages in the subject of access. For example:

- 82% of respondents were satisfied with the practice's opening hours compared with a Clinical Commissioning Group (CCG) average of 76% and national average of 75%.
- 89% of respondents found it easy to get through to the practice by phone compared with a CCG average of 71% and national average of 73%.
- 88% of respondents said they usually wait 15 minutes or less after their appointment time to be seen compared to the CCG average of 68% and national average of 65%.

Areas for improvement

Action the service MUST take to improve

- Ensure that care and treatment is appropriate and meets service users' needs by investigating and establishing the reasons for lower than average performance in the Quality and Outcomes Framework and take corrective action.
- Ensure that clinical audits in relation to patients' care and treatment complete two cycles to demonstrate improvements in the safety and quality of services provided.
- Operate a system to seek and review patient feedback on the services provided.

Action the service SHOULD take to improve

- Update the practice business continuity plan to ensure it contains up to date information.

Dr Yannamani's & Dr John's Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a GP specialist adviser and a Practice Manager specialist advisor.

Background to Dr Yannamani's & Dr John's Surgery

Dr Yannamani and Dr John's surgery is situated in Stonydelph which is a suburb of Tamworth in Staffordshire. Approximately 79% of the practice population are White British. Stonydelph has some deprived areas but has average overall levels of deprivation when compared to other areas in England.

The practice is located within a purpose-built health centre that is shared with two other GP practices, a dental practice and various community nurse services that include a walk in clinic. The practice moved into the current premises in 1986 and the property is owned by NHS Properties.

At the time of our inspection there were 1,965 patients on the patient list. The practice has two GP partners, one male and one female who combined equated to 0.95 whole time equivalent. In addition, there is a practice nurse employed. The administrative staff consists of a practice manager, senior receptionist and three administration staff. The practice is open from 8.30am until 1pm and 2pm to 6pm Monday to Friday. The phone lines remain open between 1pm and 2pm for urgent calls. There are extended hours offered until 7.15pm on alternate Tuesdays and Thursdays. Patients requiring a GP outside of normal working hours are signposted to the out-of-hours provider and telephone calls are diverted. The practice has a General Medical Services (GMS) contract and also offers enhanced services for example: various immunisation schemes, extended hours and remote care monitoring.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the service under the Care Act 2014.

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?

Detailed findings

- 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 the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 1 December 2015.

We spoke with a range of staff including both GP partners, the practice nurse, the practice manager and members of reception staff during our visit. We sought the views from patients using comment cards and reviewed data from the National GP Patient Survey published in July 2015.

Findings

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. We saw copies of minutes taken when the practice carried out an analysis of the significant event. Five significant events had been recorded over the past 12 months. The system was effective for recording and reviewing significant events and clinical alerts but was not robust enough to evidence that action had been taken resultant from the reviews, for example,

- Significant events were reviewed by two members of staff. Some staff we spoke with could not recall a recent event and records we reviewed did not contain information that significant events had been shared with all staff.
- A change of procedure had been recommended following an event that involved a patient who took medicines to minimise the chance of blood clots. The patient was seen at the practice with symptoms that may have been related to side effects of the medicines. There was no evidence of the new procedure being implemented or reviewed. The event was recorded in February 2015 and the change of procedure was to put an alert message on the patient screen of the practice's computer system.

We reviewed how the practice team responded to clinical alerts. We used an example of an alert issued in September 2014 by the Medicines and Healthcare Products Regulated Agency (MHRA) about a medicine to treat nausea and vomiting. A GP was aware of the alert, although was unsure the action taken by the practice in response to it. The practice sent information shortly after the inspection that a member of the Clinical Commissioning Group (CCG) medicines team had completed an audit and the GP had made the appropriate changes to patient records.

We reviewed the minutes of practice meetings and there was no recording that showed significant event learning outcomes and clinical alerts had been discussed. The practice stated that information is shared informally between clinicians on a regular basis but not all clinicians could recall significant events from the past twelve months.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding lead for both children and vulnerable adults. There were policies in place for safeguarding vulnerable adults and children which were accessible to all staff. Contact details for further guidance were available in the policy and contact details for safeguarding teams were displayed in each room. Staff demonstrated they understood their responsibilities and all had received safeguarding training. The practice was unable to evidence that the adult safeguarding training completed by the GPs was level three or equivalent. Level three safeguarding training is the suggested attainment for GPs. The practice held registers for children at increased risk of harm, For example, children with protection plans were identified with alerts on the electronic patient record. The practice had established a good working relationship with the health visiting team and the district nurse that we spoke with stated that regular communication took place with one of the GPs.

A chaperone policy was available to all staff. Notices in the waiting room and consulting rooms advised patients the service was available should they need it. Staff had received training to carry out this role and all staff had received a Disclosure and Barring Service (DBS) check. DBS checks are done to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medicine audits were carried out to ensure the practice was prescribing in line with best practice guidelines.

We looked at two medicine audits with regard to the prescribing of certain types of medication. One audit had been carried out to check that the management of gout was in line with NICE guidelines and provided optimum long term care. As a consequence annual blood tests and medication reviews were completed and the second audit cycle scheduled for August 2016. The second audit reviewed the use of steroid inhalers for patients with chronic obstructive pulmonary disease (COPD). This audit

investigated if the use of steroid inhalers was in line with NICE guidelines. As a consequence medication was reviewed and when necessary, changed to conform to the guidelines.

The practice had two fridges for the storage of vaccines. The practice nurse took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medicines were in date and there were enough available for use.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

All areas within the practice were visibly clean and tidy. Comments we received from patients indicated they found the practice to be clean. Treatment rooms had hand washing facilities and personal protective equipment (such as gloves) was available. Hand gel for patients was available at the entrance to all clinical rooms. Clinical waste disposal contracts were in place and spillage kits were available. The practice had a needlestick injury policy and staff were aware of how to access it.

The practice nurse was the designated clinical lead for infection control. There was an infection control policy in place. All staff had received infection prevention and control training. The landlord of the building was responsible for cleaning all areas. Cleaning schedules were in place and the practice carried out their own annual internal audit. We saw the most recent audit had been carried out in June 2015. A legionella risk assessment had been completed and procedures were in place to prevent the growth of legionella, for example, taps were opened for three minutes weekly and a log sheet completed where sinks are not being frequently used. The infection control policy had been reviewed annually and took account of the most up to date infection control guidance.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs that demonstrated that all electrical equipment had been tested and maintained regularly. For example, all portable electrical equipment had been tested in January 2015 and medical devices were calibrated in July 2015 to ensure they were safe to use.

Staffing and recruitment

The practice had a recruitment policy that had been reviewed in the last 12 months. There were sufficient numbers of staff with appropriate skills to keep people safe. Staff worked extra hours to cover holidays and sickness. The practice employed two GPs and one nurse. The practice did employ a locum GP and a locum nurse to cover holidays. A service level agreement (SLA) was in place with an agency that provided locums.

Recruitment checks were carried out and the four files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (where required).

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was a health and safety lead although they had not received any additional training to perform this role. Staff informed us that problems with the building could be reported to an administration office within the building and were then recorded in a log book. The practice had performed a fire drill in June 2015 and there was a fire alarm system and sufficient signage evident advising on the evacuation procedure. Fire extinguishers were shared between the occupants of the building and had been regularly checked. Risk assessments were completed and reviewed annually in line with Health and Safety Executive (HSE) guidelines. For example we saw risk assessments for lone working, oxygen storage, slips and trips, manual handling and for the electrical risks present within the building.

Arrangements to deal with emergencies and major incidents

There were emergency procedures and equipment in place to keep people safe. Emergency medicines were available in the reception office and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether

Good

Are services safe?

emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Non-clinical staff had received cardio pulmonary resuscitation training in April 2014 and clinical staff in September 2015. A Defibrillator and oxygen were available and there was an agreement for these to be shared with other practices situated in the building. There was evidence that checks were performed on the equipment regularly.

The practice had a comprehensive business continuity plan in place for major incidents. A hard copy of the plan was kept offsite and an electronic copy was available for all staff to access. The plan included the emergency contact numbers for local services and staff but needed updating, for example, the practice nurse contact details had not been updated since a change in June 2015. No panic alarm policy was in place but the computer system used did have a function that could be used to alert other staff of an emergency situation.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff referred to guidelines from the National Institute for Health and Care Excellence (NICE) when assessing patients' needs and treatments. The practice stated that information was shared informally, however not all GPs knew how to access the guidelines when asked.

The practice nurse managed the care of patients with long-term conditions such as diabetes, heart disease and asthma with support from the GPs. Care was planned to meet identified needs and was reviewed through a system of regular clinical meetings. There was a robust recall system in place to identify and invite patients for their clinical review. The practice carried out a range of audits and showed us a number of clinical audits that been undertaken. None of the audits had had a second cycle completed so practice was unable to demonstrate any resultant changes from the work completed. The most recent audit on a medicine used for optimum treatment of gout did have a review date included that was not due until August 2016, but past audits on steroid inhalers and cancer diagnosis had no review dates.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a voluntary system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against the national screening programmes to monitor outcomes for patients. In 2014/15 the practice achieved 64% of QOF points which was significantly below the local Clinical Commissioning Group (92.3%) and national average (94.7%). The exception rate of 10% was higher than the national average (5.5%). Patients can be excepted if not attended or refused to attend a review having been invited on at last three occasions, or if they meet one of a set of criteria based around good clinical practice and clinical judgement. The practice was an outlier for a number of the QOF clinical targets. Data from 2014/15 showed;

- Overall performance for asthma was 28.9% compared to the Clinical Commissioning Group (CCG) average of 95.9% and the national average of 97.4%.
- The percentage of patients on the asthma register given an asthma review in the preceding 12 months was 43.9% compared to the CCG average of 73% and the national average of 75.3%.
- Overall performance for chronic kidney disease (CKD) was 34.4% compared to the CCG average of 89.8% and the national average of 94.7%.
- The percentage of patients on the CKD register whose last blood pressure reading taken in the preceding 12 months was 140/8mmHg was 36% compared to the CCG average of 81.2% and the national average of 81.2%.
- Overall performance for chronic obstructive pulmonary disease (COPD) was 45.7% compared to the CCG average of 94.3% and the national average of 96%.
- The percentage of patients on the COPD register who had a COPD review in the preceding 12 months was 57.7% compared to the CCG average of 87.8% and national average of 89.8%.
- Overall performance for diabetes was 46.5% compared to the CCG average of 86.3% and national average of 89.2%.
- The percentage of patients on the diabetes register who had been given a foot check and risk assessment in the preceding 12 months was 51.4% compared to the CCG average of 86% and national average of 88.3%.

The practice were above the CCG average in 3 areas:

- Overall performance for cancer was 100% compared to the CCG average of 98.5% and the national average of 97.9%.
- Overall performance for depression was 100% compared to the CCG average of 91.6% and the national average of 93.3%.
- Overall performance for heart failure was 100%compared to the CCG average of 98.8% and the national average of 97.9%.

During the inspection we reviewed practice supplied data to look for evidence of improvement in the current QOF performance. The practice had commissioned a person to review their QOF and make improvements. We saw the practice had introduced templates on the computer system to record the information required to meet QOF outcomes. The practice supplied data that

Requires improvement

Are services effective?

(for example, treatment is effective)

indicated significant improvements would be made in the areas of asthma, CKD, COPD and diabetes for the year ending March 2016. The diabetes management was reviewed in more detail during the inspection and evidence seen on the computer system at the practice indicated that the low scores could be attributed to incorrect coding. Patients had been reviewed and had been given advice on how to manage diabetes but the code had not been applied.

Effective staffing

Staff had received training appropriate to their roles through both online and face to face training. The learning needs of staff were identified through a system of appraisal and meetings. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions and appraisals. All staff had had an appraisal within the last 12 months.

Staff received training that included: information governance, safeguarding, fire procedures, basic life support and the Mental Capacity Act 2005.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. The practice reported that none of their patients resided in care homes at the time of the inspection. The practice held multidisciplinary team meetings every two months to discuss the needs of patients with complex needs, for example those approaching the end of their life. All meetings were recorded and the minutes shared with relevant staff. Minutes showed that the most recent meeting held in October 2015 had been attended by the district nurse, community matron and staff from social services.

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.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them.

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

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. One GP was unaware of the Gillick competency test. 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. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. Formal training on the MCA had been arranged for all staff and those we spoke with on the day of inspection demonstrated knowledge of their responsibilities.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers and those requiring advice on their diet, smoking and alcohol cessation. Patients were referred to the relevant service for weight management and alcohol cessation advice.

The practice had a comprehensive screening programme:

- The practice's uptake for the cervical screening programme was 74.2% which was comparable to the national average of 74.3%.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Uptake was in line with national averages:

- The uptake for bowel screening in the past 30 months was 55.2% compared to the national average of 58.3%.
- The uptake for breast screening in the past 36 months was 67.7% compared to the national average of 72.2%.

Childhood immunisation rates for the vaccinations given were comparable to the national averages. For example:

- Childhood immunisation rates for the vaccinations given to under two year olds ranged from 94% to 100% and five year olds from 93.9% to 100%.

The practice worked with the health visiting team by sharing information about patients who did not attend for their immunisations:

- Flu vaccination rates for the over 65s were 69% which was lower with the national average of 73.2%.
- Flu vaccinations at risk groups were 55%, which was above the national average of 52%.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients attending at the reception desk and that people were treated with dignity and respect.

We collected 42 Care Quality Commission (CQC) comment cards. Patients were positive about the service they experienced. Patients said they felt the practice offered a good service with good access and that staff were helpful, caring and treated them with dignity and respect. They said the nurse and GPs listened and responded to their needs and they were involved in decisions about their care. Comment cards highlighted that staff responded compassionately when they needed help.

Consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Confidentiality at the reception area was managed using a partition wall to create a booth. There was a sign offering a confidential area if patients wanted to discuss sensitive issues or appeared distressed.

Data from the National GP Patient Survey published in July 2015 showed from 107 responses that the practice performance was below local and national averages when asked about the clinical consultation, For example:

- 78% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and national average of 89%.
- 78.4% said the last GP they saw or spoke to wasgood at listening to them compared to the CCG average of 90% and national average of 89%.
- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG of 87% and national average of 85%.
- 89% said that they had confidence in the last GP they saw or spoke to compared to the CCG average of 97% and national average of 95%.

The practice did have a more positive performance on questions about access and helpfulness of staff was positive, For example:

- 92% said that they found the reception staff helpful compared to the CCG average of 88% and national average of 87%.
- 81% with a preferred GP said they usually get to see or speak to that GP compared to the CCG average of 60.9% and national average of 60%.

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey July 2015 showed from 107 responses that the practice performance was below local and national averages for example:

- 77% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 77% said the last GP they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 68% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 81%.

Staff told us that translation services were available for patients who did not have English as a first language. We did not see notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Notices in the waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs and nursing staff if a patient was also a carer. There was a practice register of 11 people who were carers and carers and were being supported, for example, by offering annual health checks and advice regarding social care needs. Contact details for the Carer's Association were also provided.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had sufficient seating in the waiting area. There were notice boards that detailed health services available. The reception area had a hearing loop but no sign to inform patients. Staff told us that patients in need of immediate treatment would be seen even if not registered with the practice and without proof of identification.

The practice had no Patient Participation Group (PPG). We were told that the practice was in the process of establishing a group and we saw evidence that work had started.

Access to the service

The practice was open from 8.30am until 1pm and 2pm until 6pm on Monday to Friday. A member of staff continued to receive telephone calls between 1pm and 2pm. Evening opening times were offered weekly and alternated between Tuesdays and Thursdays when the practice remained open until 7.15pm. The practice offered emergency appointments only on a Friday afternoon from 1pm and the practice had an agreement with a neighbouring practice to provide appointments when required. The reception telephone lines remained open for urgent calls during the lunch hour. The practice offered a number of appointments each day with the GPs for patients who needed to be seen urgently. Pre-bookable appointments and telephone appointments could be booked up to four weeks in advance. Children under five were offered a same day appointment. The practice nurse worked two days per week and a phlebotomist was available in the practice three days each week. There was a walk in clinic staffed by the community team within the same building that could provide nursing on the days when the practice nurse was not at work. The practice reported that this clinic was used by patients for dressings and stitch removals but not for the management of patients with long term conditions. Patients commented that access to the practice was good. This was common with the results from the patient survey:

Results from the national GP survey published in July 2015 indicated that patients were satisfied with access to the practice:

- 98% of respondents said that the last appointment they got was convenient, which was higher than the clinical commissioning group (CCG) average of 93% and national average (92%).
- 85% of respondents said their experience of making an appointment was good, which was higher than the CCG average (73%) and national average (73%).
- 89% of respondents said that they found it easy to get through to the practice by phone which was higher than the CCG average (71%) and national average (73%).
- 88% of respondents said they usually waited fifteen minutes or less after their appointment time to be seen. This was above both the local CCG average (68%) and national average (65%).

Listening and learning from concerns and complaints

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

Information on how to complain was available in the waiting area. There was a sign and a leaflet on how to make a complaint available at the reception desk. There was a suggestions box in the waiting area.

We looked at records of complaints and reviewed the two that had been made during the last 12 months and found these had been satisfactorily handled and demonstrated openness and transparency. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. Complaints had been discussed at the quarterly practice meetings and communicated to all staff.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice did not have a written strategic plan in place to support the delivery of the practice values or **any future developments. Staff we spoke with said the practice team worked together and discussed a vision for the future but not all members agreed on the strategy. Information available to the practice was not reviewed and used to formulate a plan, for example, patient feedback had been obtained using GP questionnaire forms. These forms are a mandatory requirement of the GP revalidation process and although completed, they had not been summarised and used to create an action plan.**

Governance arrangements

The administration staff we spoke with stated that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- Clear methods of communication that involved the whole staff team and other healthcare professionals.

However the clinical governance was found to be below the expected standards. For example:

- Clinical audits had not had a second cycle completed to review the outcome against initial findings.
- Clinical policies and protocols could not be evidenced as having been implemented. For example, no system was in place to implement NICE guidelines.
- Quality and Outcomes Framework (QOF) Performance had not been reviewed and low performing areas had not been reviewed by the management team.

Confidential information was stored securely, although a shared office resulted in staff from another GP practice located in the same building having potential access to the hard copies of patient records. A risk assessment had not been completed to ensure the safety of this confidential information within the practice but the practice stated that the cabinets were kept locked and could only be accessed by practice staff.

Leadership, openness and transparency

The partners and practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. Staff told us that the partners encouraged a culture of openness and honesty and regular team meetings were held. Staff said they felt respected, valued and supported.

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

Interviews with the reception staff indicated that patient feedback was listened to, for example, the appointment system had recently been changed and was regularly audited as a result of feedback. However there was no PPG and no action plan completed in response to patient feedback. Comments we received were very complimentary of the standard of care received. However the responses on the GP being good at explaining tests and treatments, listening to patients and involving them with decisions about their care were all below both local and national averages and had not been addressed.

The practice had a patient centred approach and staff interviews demonstrated that feedback from patients was valued. Feedback from patients was encouraged and a suggestion box was on the reception desk. The NHS Friends and Family Test provided positive patient feedback, 100% of patients said they would recommend the practice. The practice did not have a patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The practice provided posters and leaflets that had recently been produced and planned to establish a group in the near future. However there was no evidence to demonstrate that the recent GP survey had been reviewed and discussed.

Management lead through learning and improvement

The practice staff told us they received annual appraisals and there was evidence that staff were supported to attend training appropriate to their roles.

The practice was actively engaged with the local Clinical Commissioning Group (CCG) and therefore involved in shaping local services. The practice partners attended the locality meeting. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Good governance Good governance was not operated as the performance in performing, or recording, care and treatment reviews on groups of patients including those recorded with Asthma, Chronic Kidney Disease, Diabetes, COPD, Osteoporosis and Mental Health were significantly below local and national averages. The provider had not been able to demonstrate improvement in practice in management of the regulated activities, as clinical audits undertaken were one cycle therefore unable to demonstrate any improvements made. 17 (1) (2) (a) (b) (d) (ii) (f) The provider did not have a process for reviewing and where necessary acting on feedback from people who used the service. 17 (2) (a)