Dr Sivasailam Subramony

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Medina Medical Centre on 7 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the population groups of older people, people with long term conditions, families and young people, working people, those patients whose circumstances make them vulnerable and those with mental health problems.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

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

Importantly the provider should:

- Ensure that issues identified from infection control audit have actions and are carried out in a timely way.

Summary of findings

- Remove plugs from sinks in all rooms and install elbow taps in clinical rooms.
- Ensure that all policies are dated.

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

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 National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information about the services offered by the practice was available and easy to understand. We also 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. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders took place.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice did not have a patient participation group (PPG) but used other methods to gain patient feedback. Staff had received inductions, regular performance reviews 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

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

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 population, those recently retired and students had been identified and the practice had adjusted the services it offered

to ensure these were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening that reflected the needs of this group of patients.

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 held a register of patients living in vulnerable circumstances and those with a learning disability. It had carried out annual health checks for people with a learning disability and these patients had received a follow-up.

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)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

Before our inspection we left comment cards for patients to complete to give their views on the service provided by the practice. We reviewed four completed comment cards that patients had left in the surgery and we spoke with four patients during our inspection.

The patients we spoke with told us they were happy with the care they received from the GP and the nursing staff. They told us that doctors were caring and efficient, made prompt referrals when necessary and ensured that they understood their condition and treatment. The National Patient Survey information we saw aligned to these views. Two patients told us that they had experienced problems with the attitude of some the reception staff and found them unhelpful.

The comments cards we reviewed were all positive and patients remarked on helpful staff, a safe and clean environment, how they were treated with kindness and listened to and that their needs were met.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Ensure that issues identified from infection control audits all have actions and are carried out in a timely way.
- Arrange for installation of elbow taps in all the clinical rooms and remove plugs from all rooms.
- Ensure that all policies are dated.

Dr Sivasailam Subramony

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP.

Background to Dr Sivasailam Subramony

The Medina Medical Centre is owned by an individual GP who employs two part time regular locum GPs, one male and one female. They also employ two practice nurses, a health care assistant, and a practice manager who are supported by several administration and reception staff.

The practice is situated near the centre of Luton and provides primary medical services to a population of approximately 5,950 patients under a General Medical Services (GMS) contract. The practice population is made up of predominantly mixed Asian patients accounting for 93% of the total practice population, which includes those of Pakistani, Indian and Bengali origin. A further 5% are white mixed European and 2% are of black ethnic origin.

The practice has a significantly higher than average number of children in the 0 to 15 years and 25 to 40 years age groups and lower than average number of patient in the over 50 age groups. The deprivation score for this area is three, which indicates higher levels of deprivation and potential greater need for health services.

When the practice is closed primary care services are provided via the NHS111 service.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 7 April 2015. During our inspection we spoke with the GPs, a practice nurse, the health care assistant, practice manager and reception and administrative staff and patients who used the service. We also observed how staff responded to patients and relatives who visited the practice on that day.

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to identify risks and improve patient safety. For example, significant event reporting and appropriate sharing of 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. We saw examples of the significant events that had been reviewed.

We saw that significant events were reviewed annually as well as being discussed at the time they occurred. We reviewed incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were discussed at the time they occurred and we saw evidence of this. There was evidence that the practice had learned from these and that the findings were shared with relevant staff at practice meetings and during daily meetings. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and completed them manually and submitted them to the practice manager to manage the process. The practice manager showed us the system used to manage and monitor incidents and we saw the policy they used for reporting incidents.

We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example, we noted that a member of reception staff had noticed an error when filing a prescription and had reported it and action had been taken. 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 the appropriate practice staff to action as necessary.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records and saw that all staff had received safeguarding training. We asked members of medical, nursing and administrative staff about their most recent training who confirmed they had received this. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw the practice had a safeguarding policy for children and flowchart showing actions to take if they considered a child to be at risk of harm. There was also a policy for safeguarding vulnerable adults. Contact details were easily accessible.

The practice had a lead GP for safeguarding both children and vulnerable adults who had received appropriate training to carry out the role. All staff we spoke with were aware who this lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. The practice manager described an occasion when they identified a patient at risk of abuse and had alerted the GP who took the appropriate action and communicated with social services.

There was a chaperone policy, which was visible on the waiting room noticeboard. (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). Nursing staff, including health care assistants, had been trained to be a chaperone. There were two reception staff who would act as a chaperone if nursing staff were not available. We saw that they had undertaken training and understood their responsibilities when acting

as chaperones, including where to stand to be able to observe the examination. We saw evidence that the reception staff who acted as chaperones had a Disclosure and Barring Service check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Discussions with the practice nurse and health care assistant demonstrated they were aware of the importance of safe storage and managed this in accordance with best practice guidelines.

Processes were in place to check medicines were within their expiry date and suitable for use. We looked at a sample of medicines and vaccines and found they were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

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 both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

The practice had a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The GP told us that patients taking specific high risk medicines were also under specialist care and they monitored them in between appointments. The practice had a procedure of directly contacting patients by telephone if they did not attend for review rather than writing to them.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We spoke with the main member of staff responsible for repeat prescribing who was clear regarding their role and responsibilities and demonstrated knowledge regarding high risk medicines and repeat prescribing. They told us they had received training from the Clinical Commissioning Group (CCG) medicines management team. We saw that the practice had a policy for repeat prescribing which was appropriate. 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

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept showing daily and weekly tasks which were carried out by external cleaning staff. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy. All staff had received training about infection control specific to their role and received annual updates. We saw evidence that an infection control audit had been carried out in November 2014 and some actions had been taken to address areas of risk. However, the audit did not contain specific actions and timescales for each item. For example, there were no elbow taps in the clinical rooms and no proposed action had been recorded. The practice acknowledged this during our visit and agreed to address this.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice had instructed an external company to carry out an assessment and had addressed any issues to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and

displayed stickers indicating the last testing date. A schedule of testing was in place and the practice manager showed us the electronic record for this, stored on a compact disc. We saw evidence of calibration of relevant equipment, for example the electro-cardio graph, weighing scales, spirometer and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We noted that some reception staff had not had a DBS check as they had been with the practice for many years. However, we saw that these had since been applied for. Following our inspection the practice manager confirmed that they had now been received. When the practice use locum GPs they obtain full details from the agency regarding registration, qualifications and that DBS checks had been carried out.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system for all the staff to ensure that enough staff were on duty. All nursing, reception and administrative staff were part-time and they told us that they covered for each other in times of sickness and annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice was run by a single GP who employed two regular locum GPs, who were committed to the practice, to maintain continuity of care and ensure adequate cover was available. They had tried to recruit a partner but this had not been taken up.

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. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Risks were individually identified and were assessed and rated and mitigating actions recorded to reduce and manage the risk. The practice manager told us that any risks were discussed with the GP on a daily basis and at a staff meeting monthly where all staff attended. For example, we saw that the review of complaints had been discussed with all staff at a recent meeting.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available for use in the event of patient collapse in the surgery and when we asked members of staff, they all knew the location of this equipment and knew what to do if a patient became unwell. We saw records which confirmed that it was checked regularly and fit for use.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. They carried out in house fire training and that they practised regular fire drills. We saw that they had identified fire marshalls to supervise in the event of a fire who had been trained to carry out this role.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Discussions with the GPs and nursing staff we spoke with demonstrated they could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that changes in NICE guidance had prompted an audit of specific medication and treatment pathways by the GP which were shared with staff. We spoke with a regular locum GP during our inspection who reported they found good safe systems in place at the practice to deliver care. All the staff we spoke with and the evidence we reviewed confirmed that care was planned and delivered to achieve the best health outcome for patients. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GP told us they took overall responsibility for all clinical areas and was supported by the nurses who carried out reviews and patient education regarding long term conditions and self-management. The nurses were trained in practice nurse duties and additional long term conditions such as diabetes and respiratory conditions. The nursing staff we spoke with told us they were well supported by the GP and could discuss care and treatment at any time and did this on a daily basis. All clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GP told us this supported staff to continually review and discuss new best practice guidelines for the management of long term conditions such as diabetes. The practice nurse we spoke with provided examples of good chronic disease management and demonstrated knowledge of the patient population and the difficulties they encountered regarding healthcare. They provided examples of when they had delivered care in a different way to take into account cultural issues and ensure an understanding of the effects of poor health choices.

The GP told us they met with the Clinical Commissioning Group (CCG) prescribing lead and reviewed prescribing data for the last six months and took action where necessary. They also attended monthly CCG meetings which provided an opportunity to update on new local initiatives and any identified local needs.

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

Management, monitoring and improving outcomes for people

All staff throughout the practice demonstrated a commitment to monitoring and improving outcomes for patients and were able to describe their roles in achieving this. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes and improvement in care since the initial audit. We also saw the GP had carried out an audit on minor surgery performed at the practice which showed they were carrying out procedures in in line with their registration and national guidance. We saw an audit regarding osteoporosis which had resulted in a change of medication for specific patients in line with NICE guidance. The GP maintained records showing how they had evaluated the service and documented the success of any changes and we saw that this had been shared with staff. The nurses had also carried out an audit of cervical screening which showed inadequate tests were within an acceptable level.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of

Good

Are services effective?

(for example, treatment is effective)

preventative measures). For example, an audit concerning levels of medication used in mental illness had been undertaken and as a result staff had been educated and informed of need for close monitoring.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Staff told us that this was discussed at the regular meetings and sooner if necessary to ensure good outcomes in specific areas such as chronic obstructive pulmonary disease and asthma. The practice had a good QOF achievement and was above the CCG and national average in all areas except diabetes which was lower than that of the CCG and national average.

The practice team was small, but staff we spoke with told us how as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement and expressed commitment and enthusiasm regarding their roles.

There was a protocol for repeat prescribing which was in line with national guidance. We spoke with the staff responsible for repeat prescribing who told us they regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also told us that the computer alerted them if health checks were due for patients with long term conditions and they would inform patients. The IT system flagged up relevant medicine alerts when the GP was prescribing medicines. Discussions with the GP and evidence we saw confirmed that the GP had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and the GP had regular contact with the other members of the multi-disciplinary team on an ad hoc basis rather than a formal meeting due to the size of the practice. The GP took responsibility of all patients requiring palliative care. They told us the district nurse called to the practice most days and they called them and the palliative care nurse if there were any changes in treatment or care and visa versa. The practice manager confirmed that this took place on a regular basis.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example in asthma and diabetes. The reception staff also commented that the practice was supportive of training.

The practice nurse we spoke with supported patients with asthma and diabetes as well as general practice nurse duties such as cervical cytology and immunisations. We saw evidence that they had been trained to fulfil these duties and the nurse confirmed they attended regular updates.

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. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of 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 in place worked well.

Good

Are services effective?

(for example, treatment is effective)

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital and to prevent readmission. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Patients at high risk of admission had care plans in place and were contacted following any admission to hospital. We saw that the process for dealing with hospital communications was working well in this respect.

The practice did not hold formal multi-disciplinary meetings but spoke with the district nurse and palliative care nurse regularly regarding patients, for example those with end of life care needs. The practice told us that the district nurse called in to the surgery most days and there were 21 patients on the palliative care register. The GP called the palliative care nurse or other agencies if there were any changes in care or treatment. The practice manager gave an example of when the practice had appropriately contacted social services in response to a vulnerable adult. Staff reported good communication with other agencies despite not having formal meetings.

The practice provided clinics for patients with long-term conditions such as diabetes and asthma and told us that they met with the diabetes specialist nurse to discuss best treatments and difficult cases. They also communicated regularly with the local specialist tissue viability nurse and respiratory team to ensure best practice and co-ordinated care for patients.

Information sharing

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

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. Staff we spoke with told us they had received extensive training on the system and this was ongoing as new facilities in the system developed. All staff commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a policy in place regarding consent which included reference to the Mental Capacity Act 2005 (MCA) and Gillick competence. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). All the clinical staff we spoke with understood the principles of the MCA and demonstrated an awareness of the need to assess Gillick competence. Some members of staff had received formal MCA training.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The practice nurse gave examples of how they ensured that patients understood procedures by providing appropriate discussion and visual aids when necessary.

The practice had a specific consent form for minor surgery which we saw was in use. We saw that an audit had been carried out to determine if it was being used; this showed positive results.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice engaged with the local CCG to discuss and share information about the needs of the practice population which had been collected from various sources regarding the health and social care needs of the local area. This information was used to help focus health promotion activity.

Good

Are services effective?

(for example, treatment is effective)

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture in the practice to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers and record patients' blood pressure when attending for other issues.

The practice organised the NHS Health Checks for all its patients aged 40 to 75 years and hosted them at the surgery but they were carried out by the local CCG Well Being Team. Patients were followed up appropriately by the GP where necessary and further investigations offered.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were offered an annual physical health check. The practice also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation advice and support to these patients.

The practice's performance for cervical smear uptake was 73.1%, which was similar to others in the CCG area. The practice followed national guidance regarding patients who did not attend for cervical screening and had chlamydia screening packs available for patients at risk. They also signposted to the local family planning service for patients who required intrauterine contraceptive devices as these were not provided at the practice but provided advice and other methods of contraception.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was above average at 99.1% compared to 94.9% for the CCG, and again there was a clear process for following up non-attenders by the practice nurse.

The practice kept a register of patients who had been identified as being at high risk of admission. They followed up all elderly patients with long term conditions who had attended A&E in line with the enhanced service and offered advice and support to prevent exacerbation of their condition and re-admission to hospital.

The practice had a protocol for mental health and offered health checks to mental health patients including those with dementia.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with four patients during our inspection. All patients reported being treated with respect and dignity when visiting the GPs and nurses, although two patients commented that they felt some of the reception staff were sometimes rude and unhelpful. We noted that the patient survey showed that 72% of patients reported that they found the reception staff helpful compared to 86% which was the average for other practices in the CCG. Patients we spoke with told us the GPs were good at listening to them and that their needs had been met well and one patient reported how quick and efficient the GPs were at referring on to other services.

The National Patient Survey 2014 also reported that 80% and 89% of patients felt that the GP and nurses respectively were good at listening to them and 78% and 88% felt the GPs and nurses treated them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and all of them were positive about the service experienced. Patients commented on helpful staff and good doctors and nurses and that they were able to access the GPs on the phone when necessary. They also commented that the GPs always listened to them and responded with the correct care.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and we saw that this was the case. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice switchboard was located in the reception area but the reception was surrounded by glass partitions, which prevented patients overhearing potentially private conversations between patients and reception staff. We saw there was a line of demarcation on the reception area floor encouraging patients to stand away from the reception desk while other patients were being dealt with and noted that this was being adhered to during our inspection. We also noted a sign in the waiting area informing patients that the practice could accommodate private discussion with reception staff if required.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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

Care planning and involvement in decisions about care and treatment

The National Patient Survey 2014 information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 81% and 87% of practice respondents respectively said the GP and nurse involved them in care decisions respectively. Seventy-eight per cent and 88% felt the GP and nurse, respectively, were good at explaining treatment and results.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to by the GPs and nurses and felt involved in their care and explained their treatment and medication to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language but that this service was not used often as the reception staff could speak Bengali, Urdu and Guajarati and patients preferred to use them. The practice told us patients usually chose to take relatives to translate but the translation service could be used if patients wanted it.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

Patients we spoke with told us that the GPs and nurses were good at explaining things and listening to them. The nurse told us that they spent time with patients and found different methods of explaining their conditions to help them understand how to deal with it. For example, showing them the equipment they may need to use to manage their condition, and explaining what the medication looks like and what its effects were.

Staff told us that carers were identified as soon as possible and signposted to support groups as well as being input onto the carers register to ensure they obtain the appropriate services and help required. We saw written information available in the waiting room for carers to ensure they understood the various avenues of support available to them and the practice had a carer's policy. We saw notices in the patient waiting room which directed patients to various support groups and organisations such as the drug and alcohol support service, asthma support and AgeUK.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice engaged regularly with the local Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw data which had been discussed at these meetings and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from Healthwatch as well as verbal feedback from patients in the absence of a patient participation group (PPG). For example, they had implemented a yellow line in the reception area to promote privacy at the reception desk and had introduced online appointments and prescriptions just prior to our inspection. Therefore, this was in its early stages and not fully utilised by all patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services particularly a high number of patients from ethnic minority groups. As a result all reception staff spoke three of the most popular Asian languages. Whilst translation services were available the practice reported that patients preferred to use the reception staff or a family member to translate.

The premises and services had been adapted to meet the needs of patient with disabilities. There was a ramp for wheelchair access and the waiting area was large enough to allow the easy manoeuvre of prams or for patients using mobility aids.

The practice was situated over two floors of the building with most services for patients on the ground floor, for example the main GP and practice nurse. Whilst there was no lift access to the first floor, the practice told us that if patients with mobility issues needed to be seen they would be accommodated in the ground floor consulting rooms.

Accessible toilet facilities were available for all patients attending the practice.

Access to the service

Appointments were available from 8am to 7pm on Mondays and Fridays, 8am to 8pm Tuesdays and Thursdays and 8am to 12.30pm on Wednesdays when only patients needing an urgent consultation would be seen. Patients who needed to see a doctor on the same day could be called back by the doctor to assess the need for an urgent appointment or home visit.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. The online booking information was not available on the practice website as this was in its infancy and still being developed when we inspected. The practice manager told us that this was being introduced into the website shortly. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were generally satisfied with the appointments system. Patients we spoke with confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice's extended opening hours were daily on weekdays with the exception of Wednesday when the surgery closed for appointments at 12.30pm. During this time, the practice doors remained open with the GP on site, who carried out their administrative work and was available to see patients who needed an urgent consultation or telephone advice.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. We saw that the complaints leaflets were available for patients in the waiting area. However, the practice manager told us that due to the nature of the patient population, most people liked to raise concerns and complaints verbally as their first language was not English and written English was a more difficult form of communication.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We saw that five complaints received in the last 12 months had been verbal and two written. We found that these had been responded to in and dealt with in a timely manner and followed up appropriately with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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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

Whilst we did not see a written vision for the practice, all the staff we spoke with told us that they felt that the practice was committed to improving the patient experience, deliver high quality care and promote good outcomes for patients.

The staff we spoke with demonstrated a commitment to the achieving these outcomes. They reported feeling well supported and told us that they considered the practice to have an open and honest approach and genuine commitment to sharing learning in order to improve services for patients.

We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff told us there was good communication in the practice and all staff felt involved in the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a selection of these policies and procedures and saw they were appropriate but that some were not dated to enable the practice to determine when a review was due. Staff we spoke were aware of the policies and how to access them.

There was a clear leadership from the GP and practice manager and staff were allocated specific roles. For example, the practice nurse was the lead for infection control and the GP was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing above the national standards in all areas except diabetes. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice carried out clinical audits in response to changes in guidelines and best practice to monitor quality and systems and identify where action should be taken. For example, an audit on depression to determine if patients had been properly assessed.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risks individually, for areas such as fire and legionella. We saw that risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example, a legionella assessment had been carried out and subsequent work commissioned to rectify areas of risk.

The practice held monthly meetings as well as daily informal meetings to ensure good communication in the practice. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held six weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, whistleblowing which were in place to support staff. We saw the electronic staff policies that were available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through verbal conversations with patients and verbal and written complaints and the national GP patient survey and Healthwatch. The practice had received some requests from patients that online appointment bookings would be beneficial as well as online repeat prescribing. However, these are now contractual requirements. As a result the

Are services well-led?

Good

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

practice have investigated this service and implemented it just prior to our inspection. It was not fully developed and advertising and patient awareness was to be made more accessible and more information to be put onto the website. However, they had received some utilisation of this service already.

The practice did not have a patient participation group (PPG) and was continually trying to attract interest from patients. They did tell us that any suggestions are taken forward as they are often only verbal.

The practice had gathered feedback from staff through daily conversations and discussions and six weekly practice meetings. 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice nurse told us they had been well supported by the GPs in their role and could discuss clinical issues at any time. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. From discussions with staff we noted that they were committed and enthusiastic with a caring approach to their work.