Dr P and S Poologanathan

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr P and S Poologanathan's practice on 18 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. The practice requires improvement for providing safe services. It was also good for providing services for older people, people with long term-conditions, families, children and young people, the working age (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

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

The areas where the provider must make improvements are:

Summary of findings

- Ensure appropriate standards of cleanliness and hygiene in relation to the premises occupied for the purpose of carrying out the regulated activity are met. To ensure the leads for infection control undertake training in infection control and are able to provide advice on the practice infection control policy and carry out staff training. Undertake infection control audits at periodic intervals.

In addition the provider should:

- Ensure learning is communicated to the wider reception team, not directly involved with a significant event and are given opportunities to raise an issue for consideration and share good practice at regular practice meetings.
- Ensure non clinical staff who undertake formal chaperone activities are suitably trained.
- Ensure a Legionella risk assessment is completed to reduce the risk of infection to staff and patients.
- Ensure the monitoring of audit results to ensure any negative results are addressed.
- Ensure a fire risk assessment is completed to maintain fire safety.
- The practice nurse to be aware of the Gillick competencies.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned by clinical staff but not communicated to the wider non clinical staff team to support improvement. Although non clinical staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination, they had not been formally trained to be a chaperone. Infection control processes were absent and staff had not received training in the prevention and control of healthcare associated infection. A legionella risk assessment had not been completed to reduce the risk of infection to staff and patients. Records also did not demonstrate the practice had carried out a fire risk assessment to maintain fire safety and that staff were up to date with fire training and practised regular fire drills.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff appraisals and personal development plans were in place for all staff.

Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

Improvements could be made to the monitoring of audit results to ensure any negative results were addressed.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The data from the GP Patient Survey 2014 told us patients had confidence in the clinical staff they saw. For example, most patients said they had confidence and trust in the last GP they saw or spoke to. Patients were positive about their experience during consultations with the GPs and said the GPs were good at listening to them. We also saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. The practice responded quickly to issues raised and learned from complaints.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. The practice advertised their mission to 'promote the health of their patients by providing high quality comprehensive, personalized health care' on their website. Although the vision had not been communicated to staff, the six members of staff we spoke with knew and understood their responsibilities to deliver high quality care and promote good outcomes for patients.

There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients. The patient participation group (PPG) was established and feedback from the group was always acted on.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Older people were cared for with dignity and respect. The practice was responsive to their needs, and there was evidence of working with other health and social care providers to provide safe care. We found that older patients identified as at risk of isolation were discussed at monthly multi-disciplinary meetings to monitor their care and address the support they required as necessary. Home visits were also made to older patients. There was evidence of learning and sharing of information to help improve care delivery. There were structured and meaningful discussions in meetings to resolve issues in a time-bound and effective manner.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions There was evidence of effective and responsive care to patients with long term conditions (LTCs). Clinical staff had the knowledge and skills to respond to the needs of patients with cardiovascular diseases, diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD). Patients with long term conditions requiring repeat prescriptions were being seen, and reviews of their medications were undertaken regularly. 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.

There was a palliative care (end of life) register and patients on the register were discussed at the monthly meetings. Patients with suspected cancers were referred and seen within two weeks. Longer appointments were also available for people who needed them.

Families, children and young people

Good

The practice is rated as good for care of families, children and young people. The practice was responsive to the needs of the group. There were suitable safeguarding policies and procedures in place, and staff we spoke with were aware of how to report any concerns they had. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Records demonstrated good liaison with partner agencies such as the police and social services.

Summary of findings

The practice offered a full range of immunisations for children, which included travel vaccines and flu vaccinations in line with current national guidance. Last year's practice performance for all immunisations was above the Clinical Commissioning Group average and there was a clear policy for following up non-attenders by the named practice nurse. Appointments were made available outside of school hours for children and young people.

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 practice offered extended opening hours for appointments on Tuesdays from 18.30 pm to 20.00 pm and offered late afternoon appointments between 16.30 pm and 18.30 pm every week day except Thursday to working age people. Patients could book appointments or order repeat prescriptions online.

The practice was performing well in undertaking cervical smear examinations and performance for cervical smear uptake was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. The uptake for health and blood pressure checks for working age patients was high and the practice offered NHS Health Checks to all patients aged 40-75.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Patients attending the practice were protected from the risk of abuse because reasonable steps had been taken to identify the possibility of abuse and prevent abuse from happening. The practice had policies in place relating to the safeguarding of vulnerable adults and whistleblowing and staff we spoke with were aware of their responsibilities in identifying and reporting concerns.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. 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 and they were all offered an annual physical health check. The practice registered all patients who were homeless.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice provided a caring and responsive service to people experiencing poor mental health.

Of those patients diagnosed with dementia 83.33% had received an annual review of their health. There were 22 patients on the mental health register and 66% of these patients had a comprehensive care plan document. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The practice had told patients experiencing poor mental health about how to access counselling services. Clinical staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP Patient Survey 2014 and a survey of 55 patients undertaken by the practice from December 2014 to January 2015. These highlighted patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw, particularly the GPs. For example, out of 103 patients who completed the survey, 90% said they had confidence and trust in the last GP they saw or spoke to and 71% of patients said the last nurse they saw or spoke to was good at treating them with care and concern. Patients were positive about their experience during consultations with the GPs with 80% of practice respondents saying the GP was good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 45 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Areas for improvement

Action the service MUST take to improve

- Ensure appropriate standards of cleanliness and hygiene in relation to the premises occupied for the purpose of carrying out the regulated activity are met. To ensure the leads for infection control undertake training in infection control and are able to provide advice on the practice infection control policy and carry out staff training. Undertake infection control audits at periodic intervals.

Action the service SHOULD take to improve

- Ensure learning is communicated to the wider reception team, not directly involved with a significant event and staff are given opportunities to raise an issue for consideration and share good practice at regular practice meetings.
- Ensure non clinical staff who undertake formal chaperone activities are suitably trained.
- Ensure a Legionella risk assessment is completed to reduce the risk of infection to staff and patients.
- Ensure the monitoring of audit results to ensure any negative results are addressed.
- Ensure a fire risk assessment is completed to maintain fire safety.
- The practice nurses to be aware of the Gillick competencies.

Dr P and S Poologanathan

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 who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Dr P and S Poologanathan

Dr P and S Poologanathan operate from 261 Dagenham Road, Romford, Essex, RM7 0XR.The practice provides NHS primary medical services to just over 3,000 patients in the Dagenham area. It also provides two secondary care services including minor surgery and an anti-coagulation clinic.

The practice is part of the Havering Clinical Commissioning Group (CCG). It comprises of two full time GPs, male and female, one practice nurse, a practice manager and a small team of administrative staff. The practice is not a GP training practice but provides placements for Medical students as part of their community based medical education.

Appointments were available from 8.30 am to 18.30 pm on weekdays from Monday to Friday. GP consultation times were from 10.30 am to 12.30 pm and then 16.30 pm to 18.30 pm Monday to Friday. Extended opening hours were available on a Tuesday from 18.30 pm to 20.00 pm. The practice did not close during the day and the appointment line remained open and patients could walk into the practice and book an appointment. Set hours were also in place for telephone consultations every day and urgent appointments were made available each day. The out of hours services were provided by a local deputising service to cover the practice when it was closed.

The practice provides NHS primary medical services through a General Medical Services contract (General Medical Services agreements are locally agreed contracts between NHS England and a GP practice) and provides a full range of essential services including maternity services, child and adult immunisations, family planning clinic, and contraception services. It also provides two secondary care services including minor surgery and an anti-coagulation clinic.

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.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 March 2015. During our visit we spoke with a range of staff such as both GP partners, the practice nurse, practice manager and administrative staff. We reviewed personal care or treatment records of patients.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. We reviewed safety records and incident reports from the last two years. These showed the practice had managed incidents consistently and could show evidence of a safe track record over the long term.

It reported incidents and used national patient safety alerts to protect patients. National patient safety alerts were disseminated by the practice manager to all practice staff through email. Both GPs and the practice nurse we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They told us about a recent Ebola Virus alert and the action they had taken to implement the alert.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice manager used incident forms on the practice computer system and showed us the process to manage and monitor these. There were records of significant events that had occurred during the last five years and we reviewed the last two years. 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 saw a patient who was taken to the local Accident and Emergency Department and was diagnosed with duodenal cancer. Learning was discussed at a meeting following the event. All staff involved with the patient attended the meeting and they discussed what they could have done better and learning and development was identified.

Another recent significant event recorded that a parent when hugging their child whilst the practice nurse administered a vaccine, came into contact with the needle and sustained a needle stick injury and the child was exposed to cross contamination. Two days after the event, a meeting with all clinical staff and some non-clinical staff took place. Learning was identified and clinical staff were advised on how to involve parents in a safe and controlled manner and the parent was tested for blood borne infections.

We did not see written evidence to demonstrate that significant events were discussed routinely with all reception staff. Significant events were not a standing item on the practice meeting agenda and practice meetings were not taking place on a monthly basis and only three had taken place in 2014. This did not always ensure that learning was communicated to the wider reception team, not directly involved with the significant event.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of the staff team about their most recent training. 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 knew how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible which were on the shared computer system and displayed in staff offices.

The practice had appointed one of the GP partners as the dedicated GP lead in safeguarding vulnerable adults and children. Both GPs and the practice nurse had been trained to Level three in child safeguarding. All other non-clinical staff had received a safeguarding update from the lead GP during a practice meeting in May 2014. They demonstrated they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice used a computer programme which alerted clinical staff when seeing patients if they were identified as vulnerable. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The records demonstrated good liaison with partner agencies such as the police and social services.

Requires improvement

Are services safe?

We saw the vulnerable adults register which included eight patients and the children's risk register which included 28 patients. Clinical staff had not attended child protection case conferences and reviews in the last two years but received the necessary reports if they could not attend.

There was a chaperone policy, but this was not visible on the waiting room noticeboard and in consulting rooms. (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). It was displayed behind the reception desk and was not openly visible to patients. When speaking to patients, one patient was able to tell us about the experience of being chaperoned and this evidenced that staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice nurse and a member of the reception team acted as a formal chaperone. The member of staff had not been formally trained to be a chaperone. Both members of staff had a Disclosure and Barring Service (DBS) check, which enabled employers to check the criminal records of employees.

Medicines management

We checked medicines stored in the treatment room and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Fridge temperatures were taken each day and an audit trail was kept.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of appropriately.

The practice nurse 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 nurse had received appropriate training to administer vaccines. The practice nurse had received training in chlamydia screening, sexual health, family planning appreciation and updates in medicines management, anaphylaxis, travel vaccine, wound care and tissue viability.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The GP advisor supporting us on the inspection checked eight anonymised patient records which confirmed that the procedure was being followed.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Fabric curtains were in place in each treatment room except the practice nurses' room. This room did not have any curtains around the examination couch. Written records to evidence the curtains were cleaned every six months were not in place.

One of the GPs and the practice nurse lead the practice on infection control but had not undertaken training in infection control to enable them to carry out staff training. Infection control was also not covered in the staff induction programme and staff had not received infection control training specific to their role or received annual updates. Infection control audits had not been completed for the last three years and therefore the practice had not identified any improvements for action.

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. We spoke to one of the practice nurse, who gave us examples of when she would use personal protective clothing. There was also a policy for needle stick injury,

Notices about hand hygiene techniques were displayed in staff and patient toilets, but not in all treatment rooms. Hand towel dispensers were available in treatment rooms. All rooms had hand washing sinks but out of the four treatment rooms, one room was without hand soap and two treatment rooms did not have hand gel.

Requires improvement

Are services safe?

The practice did not have a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella risk assessment had not been completed to reduce the risk of infection to staff and patients.

Records for cleaning of practice which was completed everyday by an external cleaning contractor were kept.

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. Portable electrical equipment was routinely tested and displayed stickers indicated the last testing date was in 2014. We saw evidence of calibration of relevant equipment completed on an annual basis such as the vaccine fridge, spirometer, weighing scales, defibrillator and nebuliser.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. No new members of staff had been recruited in the last five years. The files for one reception member of staff and a clinical member of staff we looked at had registration with the appropriate professional body and both staff members had a Disclosure and Barring Service check (DBS), which enabled employers to check the criminal records of employees.

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 in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including clinical and administrative staff, to cover each other's annual leave.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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 had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the identified health and safety representative.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.

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 including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of the equipment and records confirmed that it was checked regularly.

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, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked including medicines in the GPs home visit bags, were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that impacted on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of power, water, the burglar alarm and adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Requires improvement

Are services safe?

The practice had not carried out a fire risk assessment to maintain fire safety. Records showed that staff were not up to date with fire training and did not practise regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

We saw the minutes of integrated case management meetings where patients' complex care plans were discussed with other clinical staff such as the community matron and district nurse, to ensure their care was planned and coordinated. The staff we spoke with and the evidence we reviewed confirmed that assessments were designed to ensure that each patient received support to achieve the best health outcomes for them.

The GPs told us they lead in specialist clinical areas such as safeguarding, minor surgery, medication management and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of sexual health, respiratory disorders and vaccines. Our review of training records for the practice nurse confirmed this happened.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within 72 hours to one week by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings with the integrated case management team where regular reviews of elective and urgent referrals were made.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, 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 five clinical audits that had been undertaken in the last two years. Two of these were completed audits. The first completed audit was on chronic kidney disease (CKD). The first cycle was completed in 2013 and the second in 2014. The actions to improve the care of those diagnosed with chronic kidney disease were highlighted in the audits and one of the aims of this audit was to increase the number of patients tested for the abumin-creatinine ratio (ACR readings). However, the second audit cycle showed a decline in the number of patients tested for the abumin-creatinine ratio (ACR readings). Significant increases in the readings for patients could signal the precursor to the start of CKD. The decline of readings and the results of the audit were not addressed or monitored by the practice.

The second completed audit was on the interaction between Nonsteroidal anti-inflammatory drugs (NSAIDS) and warfarin. The audit was started in 2014 and completed in February 2015. Sixty patients were randomly selected

Good

Are services effective?

(for example, treatment is effective)

and it was identified that these patients tend to be on more than three medications and for GPs to opportunistically offer them a medication review. Audits were also completed in chronic disease management, prescribing and patient review, a therapy review of osteoporosis, calcium and vitamin D, to confirm that the GPs were working in line with their registration and NICE guidance.

The practice used the information collected for the QOF, a system the practice completed to monitor their performance and in return for good practice received payment, to measure their performance against national screening programmes to monitor outcomes for patients. Out of 1267 patients who required a blood pressure check, 94.08% had been seen and out of 797 patients who required a smear test, 77.54% had been seen. The practice was on target for blood pressure checks for patients with diabetes and had seen 79.88% of patients. The practice met all the minimum standards for QOF in diabetes, asthma, Chronic Obstructive Pulmonary disease (COPD). For example they had diagnosed 87.50% of their patients with COPD confirmed by bronchodilator spirometry.

Twenty one patients were on the palliative care register and were discussed at the monthly integrated case management meetings consisting of other health care professionals. The practice had 22 patients diagnosed with severe mental health and 15 of these patients had a comprehensive care documented in the last 12 months.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as coronary heart disease and that the latest prescribing guidance was being used. In the last 12 months 70.26% of these patients had received a medication review and 85.71% of patients aged over 75 years on six or more repeat prescriptions had also received a medication review in the last 12 months.

There was a system for reviewing repeat medications for patients with co-morbidities/multiple medications, which was also monitored by the quality outcomes framework (QOF). There were 401 patients with more than four repeat prescriptions which were monitored and reviewed through QOF. During the last 12 months, 295 of these patients had received a medication review.We looked at the medical records of four patients with chronic diseases and found appropriate medication had been reviewed and prescribed. The IT system flagged up relevant medicine alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and where they continued to prescribe it. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice had a palliative care register of 21 patients and had monthly external multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice nurse also offered an anti-coagulation clinic. The clinic was a service established to monitor and manage the medication(s) that patients took to prevent blood clots.

The practice also participated to a degree 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. For example the local CCG provided a lot of data and feedback to local practices and a CCG wide network incorporating this feedback and a lot of other aspects such as policies was in place.

Effective staffing

Practice staffing included two full time partner GPs and one practice nurse, a practice manager and a small team of administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory training courses such as annual basic life support and safeguarding adults. We noted a good skill mix among the GPs and practice nurse. Both GPs were up to date with their yearly continuing professional development requirements and had been revalidated. The first partner GP had been revalidated in February 2015 and the second was due revalidation in October 2015. This is a process where 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 discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example such as learning disabilities health checks, dermatology, cardio vascular disease, managing

Good

Are services effective?

(for example, treatment is effective)

diseases, dementia training and performing spirometry, which the practice nurse had attended. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. The lead GP also informed us that when he was out of the country he contacted his students via the internet for supervision.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, for the administration of vaccines and cervical cytology the nurse had received cytology updates and vaccines updates. The nurse also saw patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease and sexual health and was also able to demonstrate that she had appropriate training to fulfil this role.

Working with colleagues and other 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. 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. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately. The practice aimed to action all correspondence on the day it was received but was working a 10 day back log for discharge summaries.

The practice worked with other service providers to meet patient's needs and manage complex cases. It held monthly integrated case management meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. We saw records of meeting minutes which confirmed that these took place. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. 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; the practice used the Choose and Book system, which enabled patients to choose which hospital they would like to be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

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. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E.

The practice had systems to provide staff with the information they needed. Staff used electronic patient records 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

Both GPs and practice nurse we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this legislation. All three had received training in the Mental Capacity Act 2005. 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.

Both GPs demonstrated a clear understanding of Gillick competencies. These helped clinicians to identify children aged under 16 who had the legal capacity to consent to medical examinations and treatment. However, the practice nurse was not aware of the Gillick competencies and was consulting with this age group on her own.

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 had met with the Public Health team from CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care

Good

Are services effective?

(for example, treatment is effective)

needs of the local area. This information was used to help focus health promotion activity. One the GPs also attended the monthly local CCG cluster meetings which consisted of four practices.

It was practice policy to offer a health check with the practice nurse 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 among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. Patients aged 18-25 were offered opportunistic chlamydia screening and smokers were offered smoking cessation advice. QOF data showed us that 91.33% patients were identified as smokers, 88.78% were given smoking advice in the last 12 months.

The practice also offered NHS Health Checks to 1278 of its patients aged 40-75. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

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 which included six patients and they were all offered an annual physical health check. Five patients had not responded to the invitation for the health check and the practice sent reminder letters and contacted patients individually.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 80.27%, which was slightly below the national average. The practice offered telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. The practice nurse was responsible for following up patients who did not attend screening or whose results had inadequate cells. The nurse showed us her system for monitoring and managing these patients which was very thorough.

The practice offered a full range of immunisations for children, which included travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. The practice was at 90% for completing standard immunisations.

The practice offered sexual health advice to patients at sexual health clinics which included advice on contraception.

The practice registered patients who were homeless and also registered local traveller families who had recently settled in the area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP Patient Survey 2014 and a survey of 55 patients undertaken by the practice from December 2014 to January 2015. These highlighted patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw, particularly the GPs. For example, out of 103 patients who completed the survey, 90% said they had confidence and trust in the last GP they saw or spoke to and 71% of patients said the last nurse they saw or spoke to was good at treating them with care and concern. Patients were positive about their experience during consultations with the GPs with 80% of practice respondents stating the GP was good at listening to them. We received 45 completed cards and the majority were positive about the service experienced. Patients completed CQC comment cards to tell us what they thought about the practice. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We spoke with nine patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

However, eleven comments were less positive about their experiences with clinical staff and there was a common theme to these. Seven comments were based on the clinical staff not listening and spending enough time explaining diagnosis and treatments. The GP Patient Survey also highlighted a lower number of respondents answering positively to questions about their experiences with the practice nurse. For example, 64% of patients said the last nurse they saw or spoke to was good at listening to them and 68% said the last nurse they saw or spoke to was good at explaining tests and treatments to them. The issues had been recently identified by the practice and they had incorporated questions about patients' experiences and satisfaction with clinical staff into their own practice survey. The practice overall had a positive response with most patients describing their experiences as good, very good or excellent. The action plan devised by the practice had set itself a target to further improve patient and clinical staff relationships through the Patient Participation Group and provide training to staff in customer relations.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Fabric curtains were provided in four out of the five treatment rooms, so that patients' privacy and dignity was maintained during examinations, investigations and treatments. The practice nurse's room did not have curtains around the examination couch, which was discussed with the practice. We noted treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. In response to patient confidentiality, patients could speak to reception staff in a private room and notices were displayed in the reception areas informing patients of this option.

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 conduct an investigation 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.

Staff had not received training in equality and diversity.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed and comment cards we received showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 72% of respondents said the GP involved them in care decisions and 75% per cent of patients felt the GP was good at explaining treatments and results.

Good

Are services caring?

Patients we spoke to 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 and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Most patient feedback on CQC comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

Clinical staff offered patients information as to what to do in time of bereavement. A patient also told us their GP called them at home following a bereavement to offer support and visited the hospital their family member was admitted to.

We saw notices in the patient waiting room, sign posting patients on how to access support groups and organisations. We were told carers could also access advocacy services and were shown information on local carer and support groups that clinical staff gave to carers.

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 people's 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 had a Patient Participation Group (PPG). We spoke with four members of the PPG who said they were very happy with the efforts the practice had taken to involve patients in their care and the action that was being taken to improve patient care. They felt that their concerns were listened to and suggestions were always implemented.

The needs of the practice population were understood and systems were in place to address identified needs. The practice used a risk assessment tool which helped clinical staff to detect and prevent unwanted outcomes for patients and compare their performance with other practices. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We saw the numbers of patients on the learning disability register, those experiencing poor mental health, children and adults on the vulnerable risk register and patients with dementia. There was a palliative care register and the practice had regular monthly integrated case management meetings, which we saw minutes of, to discuss patients, their family's' care and support needs.

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

The premises and services had been adapted to meet the needs of people with disabilities and there was pram and wheelchair access throughout the premises. As well as a wheelchair accessible toilet there were baby changing facilities. The practice was situated on the ground floor with all services for patients operating from this floor.

Access to the service

Appointments were available from 8.30 am to 18.30 pm on weekdays from Monday to Friday. GP consultation times were from 10.30 am to 12.30 pm and then 16.30 pm to 18.30 pm Monday to Friday. Extended opening hours were available on a Tuesday from 18.30 pm to 20.00 pm. The practice did not close during the day and the appointment line remained open and patients could walk into the practice and book an appointment. Set hours were also in place for telephone consultations every day and urgent appointments were made available each day. The out of hours services were provided by a local deputising service to cover the practice when it was closed.

Information was available to patients about how to book appointments on the practice website which included how to arrange urgent appointments and home visits. Appointments could be booked online.

There were 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 their circumstances. Information on the out-of-hours service was provided to patients on the practice website as well through posters and leaflets available at the practice.

Longer appointments were available for people who needed them and this also included appointments with a named GP or nurse. Home visits were made to those patients who needed one, such as older patients and those with long term conditions.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and 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 and improvements had been made to the appointment system. Telephone access had been improved by the practice by implementing an additional local phone number, so patients could get through to the practice faster. One patient we spoke with told us how they needed an urgent appointment and were seen by their GP the same day. They told us they were very pleased with the appointment system.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice's extended opening hours on Tuesday evenings were particularly useful to patients with work commitments. Appointments were made available outside of school hours for children and young people

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in 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 information was available to help patients understand the complaints system such as posters displayed in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at three complaints received in the last 12 months and found all were satisfactorily handled and were dealt with in a timely way which was in accordance with the practice's complaints policy. Each complainant was written to, discussing their complaint in detail and were invited to see the practice manager with an aim to resolve their complaint.

The practice reviewed complaints on an on-going basis to detect themes and trends. Complaints were discussed at clinical meetings to ensure lessons were learned from individual complaints. We saw from the minutes that complaints were routinely discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice advertised their mission to 'promote the health of our patients by providing high quality comprehensive, personalized health care' on their website. Although the mission statement was documented and available for inspection, it had not been filtered down to staff. However, the six members of staff we spoke with knew and understood their responsibilities to deliver high quality care and promote good outcomes for patients.

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 six of these policies and procedures and they had all been reviewed annually and were up to date. However, we found that staff could not evidence that they had read and understood these policies.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse and a GP for infection control and one of the GP partner was the lead for safeguarding, medication management audits and minor surgery. We spoke with six members of staff who told us they felt valued, well supported and knew who to go to in the practice with any concerns. Members of the reception team told us they felt supported and were encouraged to learn and develop their career.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at team meetings, however these meetings did not take place on a regular basis.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. 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) which is a national performance measurement tool. The practice shared with us five clinical audits that had been undertaken in the last two years. Two of these were completed audits on chronic kidney disease (CKD) and the interaction between Nonsteroidal anti-inflammatory drugs (NSAIDS) and warfarin. For the first audit on chronic kidney disease (CKD), during the second audit cycle showed a decline in the number of patients tested for the abumin-creatinine ratio (ACR readings). The decline of readings and the results of the audit were not addressed by the practice and the impact on the quality of care was not monitored.

Leadership, openness and transparency

The practice did not hold monthly practice team meetings, which the team would benefit from by giving them further opportunities to feel actively engaged, participate in learning following significant events and share information collectively. In 2014, three practice team meetings had taken place, two in May and one in July. During the May meetings, topics such as safeguarding protocols had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and recruitment policy, which were in place to support staff. They were detailed and provided appropriate guidance for staff. There were polices on equality, 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 its practice patient surveys and complaints received. The GP Patient Survey highlighted a lower number of respondents answering positively to questions about their experiences with the practice nurse. For example, 64% of patients said the last nurse they saw or spoke to was good at listening to them and 68% said the last nurse they saw or spoke to was good at explaining tests and treatments to them. The results had been identified by the practice and they had also incorporated questions about patients' experiences and satisfaction with clinical staff into their own practice survey. The practice overall had a positive response and action plan was devised by the practice to further improve patient and clinical staff relationships through the Patient Participation Group and provide training to staff in customer relations. Patients also agreed telephone consultations would be useful. We saw as a result of this the practice had introduced telephone consultation appointments and an additional telephone line to increase patient access.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups; including older people and working age people. The group told us they needed to widen their representation and were looking at ways to do this. The PPG met every quarter.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

There were records of significant events that had occurred during the last two years and we were able to review these. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. The practice had completed reviews of significant events and other incidents.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The leads for infection control had not undertaken training in infection control and were not able to provide advice on the practice infection control policy and carry out staff training. Infection control audits had not been completed at periodic intervals. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.