Dr Sivasundaram Sivagnanasundaram

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Sivasundaram Sivagnanasundaram on 10 June 2015. Overall the practice is rated as good.

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

We found the practice to require improvement for providing safe services.

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, with the exception of equipment for medical emergencies, areas of infection control and risks relating to recruitment checks.
- 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 were very complimentary about the service and 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, although it was not available in other languages.

Summary of findings

- 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 encouraged a team approach to day to day management.
- The practice had not fully established methods to gather feedback from patients.

We saw one area of outstanding practice:

- The practice provided a tailored service for the most at risk patients, providing a one hour call back and we were provided with numerous examples where the practice met the needs of patients most at risk. They kept detailed care plans for patients at risk of unplanned admissions which clinical and non-clinical staff routinely referred to, to ensure a collective approach to patient care.

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

Importantly the provider must:

- Ensure Resuscitation Council guidance is followed regarding the provision of emergency equipment, including access to oxygen and a defibrillator.
- Ensure that criminal records checks are undertaken with the disclosure and barring service (DBS) or a risk assessment is completed for non-clinical staff who are undertaking chaperoning duties and staff are provided with chaperoning training.
- Ensure the practice has robust infection control processes in place, to include updating the infection control policy and procedures and following national guidance related to adequate waste management, Hepatitis B vaccinations for staff handling sharps, control of substances hazardous to health and providing infection control training for all staff.

In addition, the provider should:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Implement a system to track and log prescription pads used in the practice.
- Ensure all staff have access to an annual appraisal.
- Improve access to medical services for patients who require a female GP and improve access to practice nursing resources.
- Consider keeping a record of verbal complaints so that complaint themes can be identified to aid in service improvements.
- Establish ways of gathering feedback from patients to assist in improving services and establish the patient participation group.
- Ensure clinical audits are thoroughly documented to demonstrate improved outcomes for patients.

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 their responsibilities to raise concerns, and to report incidents and near misses and when things went wrong investigations were communicated widely. Safeguarding processes were robust and all staff were clear how to raise alerts. The practice had a thorough business continuity plan and a track record of equipment and maintenance checks.

Although risks to patients who used services were assessed by a variety of sources, the systems and processes to address these risks were not implemented well enough in some areas. For example, the practice did not have adequate equipment to be able to deal with emergencies, infection control processes were not fully assured and full recruitment checks had not always been completed.

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. Patients' needs were assessed and care was planned and delivered in line with current legislation for a range of long term conditions. This included assessing capacity and promoting good health.

The practice had undertaken clinical audits to monitor and improve outcomes for patients and regularly liaised with the Clinical Commissioning Group and other practices in the GP network to measure their performance.

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 some appraisals, but they were not completed routinely for all staff. The practice engaged with a number of multidisciplinary team members from local community services and held regular meetings.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice average or above for most aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive.

Summary of findings

We observed a patient-centred culture. Staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

We found positive examples to demonstrate how patients' choices and preferences were valued and acted on by clinical and non-clinical staff, including examples to illustrate how emotional needs were met. The practice had comprehensive care plans that had been agreed with patients, for the most vulnerable and complex patients. These were easily accessible for clinical and non-clinical staff to refer to when patients called the practice, so their care plans, choices and preferences were followed.

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).

Patients said they found it easy to make an appointment with a named GP and urgent appointments were frequently available the same day. However, there was limited access to a practice nurse and there was no access to a female GP. The practice prioritised appointments for those deemed at risk such as older people, patients on the unplanned admissions register and children and all staff were familiar with using the care plans to ensure patients' needs were met.

The practice had good facilities and was well equipped to treat patients and meet their needs, although there was limited space in the waiting area. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff where required.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision for patient care. 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 also encouraged a team approach to leadership in the practice and this worked well.

The practice had a number of policies and procedures to govern activity and these were frequently discussed in staff meetings, particularly around information governance procedures. There were systems in place to monitor and improve quality and manage risk, although some risks were not always identified. The practice was starting to gather feedback from patients, by beginning to establish

Summary of findings

a patient participation group, but had gathered some patient feedback via other means. Staff had received inductions, regular training and attended staff meetings and were happy to raise any concerns, however annual appraisals for non-clinical staff were not formally documented.

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, such as hypertension.

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 avoiding unplanned admissions. It was responsive to the needs of older people as it offered home visits and patients were prioritised for emergency appointments. The practice had a robust system whereby patients were able to request repeat prescriptions over the telephone if they were unable to get to the surgery. The practice ensured that over 75s had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. GPs led on long term condition reviews, chronic disease management and utilised collaborative working with local GP practices to meet targets, for example for diabetes patients. The practice had actively identified that they needed to monitor patients at risk of uncontrolled diabetes and promoted self-management and lifestyle advice. Those patients at risk of hospital admission were identified as a priority and placed on the practice register. Longer appointments and home visits were available when needed. All these patients were able to access 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.

Patients at the end of life were placed on the practice's palliative care register and the practice had meetings every two months with the palliative care team and maintained close links with a local hospice.

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 accident and emergency (A&E) attendances. The practice had

conducted an audit to identify and prevent avoidable A&E attendances by ensuring the practice could offer flexible and priority access to urgent appointments. The practice also met with a health visitor to discuss children at risk, every two months.

Immunisation rates were average or above for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

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 was proactive in offering online services such as appointment booking, access to medical records and electronic prescriptions. Telephone triage was offered with a GP. The practice were not able to offer a full range of health promotion and screening in house but actively promoted cervical screening, bowel cancer screening and breast cancer screening and had achieved a good uptake in all these areas, that reflected the needs for this age group.

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 including homeless people, adults and children at risk and those with a learning disability. The practice had a robust system whereby at risk patients were placed on the avoiding unplanned admissions register and thorough care plans were completed for each patient and were available to all staff. The patients received a one hour call back if they had care plans in place to ensure they were prioritised and given flexible access for appointments. We were provided with numerous examples where the practice met the needs of patients most at risk.

The practice had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

Summary of findings

The practice had a large representation of Tamil patients and the lead GP was able to translate and meet their needs. Reception staff frequently acted to ensure non-English speaking patients were understood and had their needs met.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Where at risk patients were discharged from hospital, they were seen for a review by a GP.

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). Sixty six per cent of people experiencing poor mental health and 100% of patients with dementia had received 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 and had improved the awareness and diagnosis of dementia in the last six months.

The practice had told patients experiencing poor mental health 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. Patients deemed at risk were placed on the avoiding unplanned admissions register and were prioritised for treatment. Home visits were carried out for this patient group where indicated, and this included routine and urgent home visits.

Summary of findings

What people who use the service say

We spoke with eight patients and reviewed 39 CQC comments cards during our inspection. We looked at results from the national GP patient survey undertaken in 2014. This had had 105 responses, which was a 25% return rate. We also looked at the results of the NHS Friends and Family Test (FFT) data from December 2014 to April 2015 and results from a patient satisfaction survey carried out by the lead GP, with 35 responses.

We found that patients had positive experiences at the practice. Patients we spoke with were highly satisfied with the care and treatment they received, and felt that they were treated with respect and were involved in their care. GP patient survey data showed that the practice were mostly above average for the local clinical commissioning group (CCG) for satisfaction with consultations with clinical staff and were significantly above average in some areas. FFT data showed that 95% of patients would recommend the practice, however the national GP patient survey found that 77% of patients would recommend the practice, which was the same as the local CCG average of 77% and national average of 78%. Ninety one per cent described their overall care as good, compared with CCG average of 83% and national average of 85%. The patient satisfaction survey carried out by the practice found that 100% of patients were confident about the care and treatment received.

From reviewing CQC comments cards, 100% of these were positive about the care provided. Twenty three per cent noted that there were occasionally problems accessing appointments, particularly access to a practice nurse.

Areas for improvement

Action the service MUST take to improve

- Ensure Resuscitation Council guidance is followed regarding the provision of emergency equipment, including access to oxygen and a defibrillator.
- Ensure that criminal records checks are undertaken with the disclosure and barring service (DBS) or a risk assessment is completed for non-clinical staff who are undertaking chaperoning duties and staff are provided with chaperoning training.
- Ensure the practice has robust infection control processes in place, to include updating the infection control policy and procedures and following national guidance related to adequate waste management, Hepatitis B vaccinations for staff handling sharps, control of substances hazardous to health and providing infection control training for all staff.

Action the service SHOULD take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Implement a system to track and log prescription pads used in the practice.
- Ensure all staff have access to an annual appraisal.
- Improve access to medical services for patients who require a female GP and improve access to practice nursing resources.
- Consider keeping a record of verbal complaints so that complaint themes can be identified to aid in service improvements.
- Establish ways of gathering feedback from patients to assist in improving services and establish the patient participation group.
- Ensure clinical audits are thoroughly documented to demonstrate improved outcomes for patients.

Outstanding practice

We saw one area of outstanding practice:

The practice provided a tailored service for the most at risk patients, providing a one hour call back, and we were provided with numerous examples where the practice met the needs of patients most at risk. They kept detailed care plans for patients at risk of unplanned admissions

which all staff routinely referred to, to ensure a collective approach to patient care. These were easily accessible for clinical and non-clinical staff when patients called the practice, so their care plans, choices and preferences were followed.

Dr Sivasundaram Sivagnanasundaram

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP Specialist Advisor and an Expert By Experience. The GP Specialist Advisor and Expert By Experience were granted the same authority to enter Dr Sivasundaram Sivagnanasundaram as the CQC inspector.

Background to Dr Sivasundaram Sivagnanasundaram

Dr Sivasundaram Sivagnanasundaram provides primary medical services in Lewisham to approximately 2030 patients. The practice is part of Lewisham Clinical Commissioning Group (CCG). Dr Sivasundaram Sivagnanasundaram is one of 44 practices in Lewisham CCG. The practice population is in the third most deprived decile in England.

The practice population has a higher than national average representation of income deprived children and older people. The practice has a lower than average number of 55-64 year olds compared with the national average and has a higher than national average for children aged five to 14 at 13.9% and higher than average number of young people aged under 18 at 17.7% The practice has a lower number of older patients aged above 65 at 12.8% compared with national average of 16.7%. Of patients registered with the practice, there are large representations from White British, Sri Lankan and Tamil backgrounds.

The practice has ground floor ramped access. All consulting rooms and patient facilities are on the ground floor. Within this building there is one consultation room, a treatment room, a patient waiting area and reception and patient toilet. The practice team at Dr Sivasundaram Sivagnanasundaram is made up of two part time male GPs, one of these being the lead GP, a locum practice nurse who attends the surgery one day per month, a locum practice manager who attends the surgery one day every two weeks and five reception and administrative staff.

The practice operates under a Personal Medical Services (PMS) contract, which is one of three main contracting routes a practice has with NHS England. The practice is signed up to a number of enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice is also subscribed to the Quality and Outcomes Framework (QOF) which incentivises practice performance.

The practice reception and telephone lines are open from 8am-6.30pm, Monday to Friday. Appointments are offered from 8.30am-12pm and 16.00 to 18.30pm Monday, Wednesday, Thursday and Friday and 8.30am to 12pm and 16.00pm to 19.30pm on Tuesdays. The practice is closed at weekends. The practice is closed for appointments between 1pm and 4pm. Home visits for housebound patients and telephone consultations are offered between 1pm and 4pm. Appointments during the morning and afternoon sessions are available pre-bookable in advance

for routine appointments as well as appointments being held for same day and emergency appointments. The practice has opted out of providing out of hours (OOH) services to their own patients and directs patients to the out-of-hours provider.

Appointments can be pre-booked with the practice nurse one day a month for cervical screening, long term conditions health checks and childhood and travel immunisations. The practice can also direct patients to utilise services at another local GP practice for family planning and cervical screening where required.

Dr Sivasundaram Sivagnanasundaram is registered as an individual with the Care Quality Commission, to provide the regulated activities of Diagnostic and screening procedures, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder and injury.

Why we carried out this inspection

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.

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

We carried out an announced comprehensive inspection on 10 June 2015. During our visit we spoke with a range of staff including two GPs, the locum practice manager, two administrative staff and two reception staff. We spoke with eight patients who used the service. We reviewed CQC comment cards completed by 39 patients sharing their views and experiences of the service. We looked at a number of medical records.

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We received information from Lewisham clinical commissioning group and NHS England.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed incident logs and a range of clinical and non-clinical incident examples that had been documented over the past year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over this period.

The practice had a policy in place where they additionally raised quality alerts if clinical incidents had been reported but wider organisations were also implicated in the incident, such as local hospitals. This aimed to improve patient safety and improve communication links between services. For example, we were told about an incident where a two week urgent referral had not been made as the blood results from the hospital had not been sent to the practice. The practice investigated this and raised a quality alert.

Patient safety alerts were disseminated to practice staff and discussed informally where appropriate, such as the Ebola alert. Patient safety alerts were not routinely discussed in team meetings.

Learning and improvement from safety incidents

The practice had one system in place for reporting, recording and monitoring clinical and non-clinical significant events, incidents and accidents. We reviewed records of seven significant events that had occurred during the last year and saw this system was followed appropriately. We saw evidence of action taken as a result and that the learning had been shared. For example, a clinical incident occurred where a patient was diagnosed with cancer after attending hospital for an unrelated issue. The practice investigated whether they could have made an earlier diagnosis, and found that they had not been informed by the hospital when the patient had not attended a previous scan appointment. The practice made a quality alert and fed back to the scanning department requesting improved communications. The practice signed up to the admission avoidance enhanced service as a result of a number of instances where feedback from the hospital was limited, to aim to improve the practice's monitoring of high risk patients.

Significant events were discussed where needed during staff meetings, but were informally discussed during clinical meetings between the two GPs. There was evidence that the practice had learned from these and that the findings were shared with relevant staff, but also the practice raised quality alerts to ensure wider learning from incidents that occurred.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw updated and comprehensive practice policies for safeguarding children and adults. The lead GP was the safeguarding lead for the practice for both adults and children. We looked at training records which showed that all staff had received relevant role specific training on safeguarding children (GPs are required to be trained to Level 3 and practices nurses to at least Level 2 for safeguarding children.) The GPs had completed safeguarding adults training but this required updating. We were informed that they had attended training shortly after the inspection.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. Staff knew who the leads were for safeguarding in the practice. 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. Contact details were easily accessible in the reception area and clinical areas. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. Reception staff were able to recall when they had to raise an alert to the local authority due to practice concerns around neglect of a patient. The GPs were able to provide examples of when they had made safeguarding referrals and discussed concerns with the clinical commissioning group (CCG) lead.

Requires improvement

Are services safe?

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 and adults at risk. The practice specifically recorded frequent child accident and emergency attendees.

There was a chaperone procedure, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. A chaperone policy was also available for staff to read. (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). The locum nurse could act as a chaperone, however due to limited sessions at the practice, reception and administrative staff would frequently act as a chaperone. Not all non-clinical staff who were chaperoning had received training, however those that had, understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Some staff chaperoning had been employed at the practice for a number of years, and we were told they had criminal records checks when they initially commenced employment. However there was no risk assessment or procedure in place to consider whether these checks needed to be updated to Disclosure and Barring Service (DBS) checks, in light of the chaperoning duties staff were undertaking. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures to maintain the cold chain, which described the action to take in the event of a potential failure. This had been updated in the last 12 months. Records showed daily fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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 in line with waste regulations.

We were shown the repeat prescribing policy and staff discussed the repeat prescribing process with us. All prescriptions were reviewed and authorised by a GP before they were given to the patient or issued electronically. Both blank prescription forms for use in printers and those for hand written prescriptions were stored securely, however the practice did not follow national guidance and track these through the practice using a log record. There was a system in place for the management of high risk medicines by use of pop up alerts on the electronic patient record. Patients on high risk medicines such as warfarin, methotrexate and other disease modifying drugs were provided with a GP review prior to re-issuing of the prescription. For patients on anticoagulant medications, the reception team requested the patient's blood record book prior to the GP issuing a repeat prescription. We checked 11 sets of anonymised patient records with long term conditions, which confirmed that all patients were reviewed by the GP prior to the issuing of a repeat prescription.

The locum practice nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance and we saw evidence of these. The nurse was a nurse prescriber, but still followed the PGD as they only worked at the practice once a month. We saw that the batch and site number for immunisations were completed in patient records.

Prescribing data was discussed in clinical meetings between the two GPs. These meetings were not recorded, however we were shown prescribing data for the practice and we were shown minutes where one of the GPs attended local CCG neighbourhood meetings where prescribing patterns for the CCG were discussed. The GPs used information on the local Clinical Commissioning Group (CCG) interactive website for latest prescribing updates.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or

infection control. We observed the premises to be mainly clean and tidy, however we noted that the floor in the consultation room was carpeted and the disposable curtains in both clinical rooms had not been changed since 2013. There were environmental cleaning schedules in place in the toilet and treatment rooms, however there were no records or schedule for the cleaning of clinical equipment including treatment couches, keyboards and phones. The practice did not have a control of substances hazardous to health (COSHH) policy or a register of COSHH products housed in the practice.

An infection control policy dated 2008 and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, there were procedures for hand washing, the use of personal protective equipment, sharps procedures and managing bodily fluids and spillages. Although not recently updated, these contained comprehensive information for staff to follow. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use, for example of handling specimens. Spill kits were available in the treatment room. Notices about hand hygiene techniques were displayed in clinical rooms and staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice lead for infection control was the lead GP, however none of the practice team had received infection control training, including the lead GP. We saw evidence that the locum practice manager had carried out infection control audits annually utilising a standardised template, the last one being in April 2015. Previous audits had had identified the need for replacement waiting room chairs and this action had been completed. The most recent audit identified that a review of the carpet in the clinical rooms was required and we were told that the practice had applied for funding to implement these improvements. The audit had not identified the need for infection control training or that more detailed cleaning records were required for clinical equipment, computers and phones. We were told that audits were shared in practice meetings or opportunistically.

Staff knew the procedure to follow in the event of a needle stick injury. Non-clinical staff assisted frequently with the removal of full sharps containers, and clinical waste. However, the practice did not have full assurance that Hepatitis B status was up to date for one non-clinical staff member who assisted with sharps disposal.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was utilising an external contractor to carry out two yearly risk assessments in line with this policy, to reduce the risk of infection to staff and patients. The practice showed un an asbestos check certificate from 2012.

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 tested and displayed stickers indicating the last formal testing date which was in 2013. The practice policy was that these items underwent visual checks yearly by the practice and full portable appliance testing occurred every 3 years. We were shown recent guidance from the Health and Safety Executive to provide the assurances that this was appropriate for the practice. We saw evidence of calibration of relevant equipment from October 2014; for example weighing scales, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff, however we noted it needed updating to include all recruitment checks that were required for new staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for one new non-clinical member of staff employed in 2014; however proof of identification and references had not been recorded for another new non-clinical staff member. Recruitment checks the practice aimed to undertake included proof of identification, references, and the appropriate checks through the Disclosure and Barring Service. (These checks identify

whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)

We noted that the practice employed a locum practice nurse and occasionally locum GPs to cover GP sessions. The practice had a robust process in place when recruiting locums, with evidence of qualifications, registration with the appropriate professional body, DBS assurance and Hepatitis B status.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff worked predictable shift patterns to ensure that enough staff were on duty. There was an arrangement in place for administrative and reception staff to cover each other's duties during periods of 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. There was access to a practice nurse one day per month, which provided a limited skill mix, with the GP frequently carrying out practice nurse duties. The practice showed us the appointments and rota system which showed that despite this, demand and capacity could be met adequately for appointments.

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 regular checks of the building, the environment, medicines management, dealing with emergencies and equipment. For example, a health and safety assessment was completed annually by an external contractor and the same company completed a two-yearly fire risk assessment. The practice also had a health and safety policy which covered a variety of health and safety information and all staff had received health and safety training. Practice liability insurance was in date and visible in the reception area.

The premises was owned by the lead GP. The practice manager completed a premises risk assessment annually as well as an infection control audit. We were told that the practice were aware that there were some areas of the premises that needed to be updated and better maintained and they had applied for funding to secure these improvements, for example, there were visible cracks in the consultation room wall and the flooring in the treatment room and consultation rooms required updating as there were potential infection control risks and trip hazards identified.

Identified risks from all risk assessments and audits were know and were shared with us, but they were not clearly recorded on a central risk log. There was evidence from staff meeting minutes that risks were discussed with staff when required, such as the risk included in the business continuity plan.

The practice did not have written policies in place for responding to patients with deteriorating health, however all staff knew the practice policy for prioritising specific patient groups for appointments and making urgent referrals.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Records showed that all staff had received updated training in basic life support. Emergency medicines and a nebuliser were available; however the practice had not followed Resuscitation Council guidance and did not stock emergency equipment including oxygen and an automated external defibrillator (used in cardiac emergencies). We asked the lead GP about this emergency equipment and we were told that the practice had never required it. Where they had called for emergency services, they attended the practice swiftly. The practice did not have a risk assessment in place detailing the decision making process as to why a defibrillator was not required. During the inspection, the practice reported that they would ensure that they ordered oxygen and would consider whether a defibrillator was required.

Emergency medicines were easily accessible to staff 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 Robust processes were in place to check whether emergency medicines were within their expiry date and suitable for use and we saw six monthly log records for these medicines. All the medicines we checked were in date and fit for use.

A disaster handling and business continuity plan was in place that was updated in 2014, to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk had an impact analysis and mitigating

Requires improvement

Are services safe?

actions recorded to reduce and manage the risk. Risks identified included power failure, loss of computer systems, loss of facilities and loss of the premises. The document also contained relevant contact details for staff to refer to, however we were told these needed updating.

An external contractor had carried out a fire risk assessment in 2013 which was valid for two years, that included actions required to maintain fire safety such as weekly testing of the manual fire alarm. Records showed that staff were up to date with fire training and that they practised fire drills, the last being in 2014.

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. For example, for diabetes and dementia.

GPs told us that NICE guidelines were taken from a clinical commissioning group (CCG) internet resource for GPs, they were shared in clinical meetings, discussed in the clinical commissioning group protected learning sessions and updates were provided in the yearly GP update course.

We reviewed a number of sets of medical records for a range of conditions and could see that best practice guidance was being followed. The GPs carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes received regular health checks and were being referred to other services when required. For 2014/15, 88% of diabetic patients had received an annual health check. For chronic obstructive pulmonary disease (COPD) the practice had completed 64% of annual reviews in 2014/15.

The two GPs told us they led in all specialist clinical areas such as diabetes, heart disease, COPD and asthma as there was limited practice nurse availability to share this work. The GPs felt that their annual reviews for asthma patients at 51% for 2014/15 may have been low due to the lack of practice nursing resource. To meet the needs of long term conditions patients, the practice took part in a neighbourhood collaborative working initiative with other practices to assist with improving co-ordination of care for patients with long term conditions and end of life care by using risk stratification, care planning and self-management.

The practice had provided annual reviews for all patients on the dementia register for the last 12 months and had completed 66% of reviews for patients on the practice's mental health register. The practice had signed up to the enhanced service for health checks for learning disability patients, and all four patients had received an annual physical health check for 2014/15. This ensured that their needs were being effectively assessed. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.)

The practice used computerised tools to identify patients who were at high risk of admission to hospital. The practice kept a folder of comprehensive care plans, which we saw, for patients on this register, so that they were utilised to ensure their needs were met and admissions to hospital were avoided where necessary. These patients were also reviewed regularly and their care plans updated. The practice had 32 patients on the avoiding unplanned admissions register and 86% had a care plan in place. Some patients had declined to have a care plan.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed 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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included accurate data input, scheduling clinical reviews, monitoring patients on the avoiding unplanned admissions register and managing child protection concerns.

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

The practice showed us two clinical audits that had been undertaken in the last two years. One of these was a completed audit to improve diabetes management. The audit in 2014 identified high risk patients with poorly controlled diabetes, shown by the patients' blood test results. Of the 11 patients identified, they were called to see the GP for a health check and referred for self-management and dietary advice. The practice changed the referral

Good

Are services effective?

(for example, treatment is effective)

process so that these patients were able to self-refer to the dietician and self-management group to ensure compliance and better control of diabetes in the long term. The audit was repeated in 2015 which showed that 64% of patients had improvements in their diabetes control, indicated by blood test results.

The second audit was a one-cycle audit, where the practice aimed to reduce the number of accident and emergency (A and E) attendances in children under 16. The practice had identified that in 2013, 90 patients under 16 had attended A and E for treatment. In 2014, 35 of those same patients had attended A and E again at least once, and 40%, were deemed by the practice as avoidable and could have been dealt with in primary care. The practice contacted the patients and parents/guardians of all the children to advise that the practice prioritised the treatment of children with either a face to face or telephone consultation. A re-audit was scheduled for later in 2015 to review whether A and E attendances had reduced.

The practice also engaged with mandatory prescribing audits for the clinical commissioning group (CCG) and had completed a cervical cytology audit twice over the last four years to reduce the number of inadequate smear test results. This showed there had been a small decrease in inadequate smear results overall.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 90% of the total QOF target in 2013/14, which was slightly below the national average of 94%. However, the practice achieved 95% of the total QOF target for 2014/15. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average for a range of blood tests and checks.
- The percentage of patients with hypertension having regular blood pressure tests was better than national average.
- Performance for mental health related QOF indicators was better than the national average.
- The dementia diagnosis rate was below the national average.
- Percentage of patients with a heart condition treated with anti-coagulant medication was above national average at 100%.

The practice was aware of all the areas where performance was not in line with national or CCG figures as they regularly obtained benchmarking figures and attended CCG neighbourhood meetings. Where some diabetes figures were slightly lower than average, the practice had commenced the diabetes audit to try and address this. They had also signed up to the enhanced service to improve dementia diagnosis and support where dementia diagnosis rate had been below average. Recent benchmarking data indicated that the practice's dementia diagnosis rate, had improved by 26% between September 2014 and March 2015 which was the second highest achievement in the CCG neighbourhood. Both GPs had attended dementia training to improve awareness.

The practice's prescribing rates were also similar to national averages for hypnotic, antibiotic and anti-inflammatory medication. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines and we were shown this process.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was evidence of care planning for these patients.

Benchmarking was also evident in relation to the practice's performance with hospital referrals and A and E attendances compared to the CCG neighbourhood. The practice were similar to expected for A and E and emergency cancer admissions.

Effective staffing

Practice staffing included two GPs, a locum nurse and managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending most mandatory courses such as annual basic life support. The GPs had also attended recent safeguarding adults and dementia awareness courses.

The GPs had a range of skills in chronic disease management including diabetes and had additional

Good

Are services effective?

(for example, treatment is effective)

experience with children's health. The GPs attended the yearly GP update course to ensure they were updated with best practice guidance. The GPs had access to training through protected learning time sessions every two months. The lead GP had additional skills in minor surgical procedures although the practice were not actively providing this service to patients. Both GPs were up to date with their yearly continuing professional development requirements and both had 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.)

We were shown the most recent appraisal for the lead GP. Non-clinical staff also had appraisals but these had not been formally documented since 2012 for the majority of staff. Our interviews with all staff confirmed that the practice was proactive in offering training and funding for relevant courses if they required it, for example the practice completed an information governance training needs analysis for staff to identify areas where training was required.

The practice employed a locum practice nurse one day a month. The practice had assurances that the nurse was trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical screening. The practice were aware that they required more practice nursing time to assist with long term condition management and health promotion and were currently trying to increase the number of practice nursing sessions available.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, scan results, and letters from the local hospital including discharge summaries and consultant appointment feedback; electronic communications were received from the out-of-hours GP services and the 111 service. The practice had a clear policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of-hours reports, 111 reports and pathology results were all scanned onto the electronic computer system and were seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually all seen and actioned on the day of receipt. There was one GP working at the practice each day, so they reviewed results and letters relating to all patients. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were 13% compared to the national average of 14% The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. We saw that the policy for actioning hospital communications was working well in this respect.

The practice also worked with local practices and services, and received and sent communications to these services, for example the local practice and sexual health clinic that carried out cervical screening and provided family planning services for patients.

Monthly multidisciplinary meetings were held to discuss complex patients; most of these had care plans and were on the practice's avoiding unplanned admissions register. The district nurses, community lifestyle matron and local authority co-ordinator also attended. We saw a number of minutes that comprehensively discussed medical and social issues with clear actions points for the team. The practice also met the palliative team and engaged with the local hospice every two months to discuss palliative care patients, although these meetings were not minuted.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. Administrative staff were trained to ensure practice activities were coded correctly and entered onto the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Good

Are services effective?

(for example, treatment is effective)

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. Results and letters were sent and received electronically or occasionally by post. Referrals were sent electronically, however urgent referrals were faxed, and the practice showed us how urgent two week wait referrals were monitored.

For patients who were referred to hospital in an emergency, there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had 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.)

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. 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. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions.)

The practice had drawn up a consent policy to help staff, and we were shown this. The policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. The practice encouraged staff to use a consent form where there were any identified risks with gaining consent.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

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 used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area. The practice attended GP neighbourhood meetings where this information was shared.

It was practice policy to offer a health check to all new patients registering with the practice. The GP completed all new health checks. For the previous year 2014/15, 66% of patients accepted the offer of a new patient health check. The practice also offered NHS Health Checks with a GP to all its patients aged 40 to 74 years. There was a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing and we saw evidence of this in patient records. For example, by opportunistically promoting health checks, referring to a lifestyle hub for weight management and offering smoking cessation advice to smokers.

The practice was pro-active in offering additional help to those that needed it. For example, the practice had identified the smoking status of patients over the age of 16, with 108 patients, or 5% of the practice population classed as smokers. The practice actively offered appointments with the locum nurse, GP or community support-led smoking cessation clinics to 100% of these patients. However, in the last 12 months, only 8% of these took up the offer of a referral. Of those referred, there was a 33% success rate.

The practice's performance for the cervical screening programme was consistently higher than national average of 82%, having attained 89% in 2013/14 and 85% in 2014/15. To promote uptake as they did not have a regular practice nurse, the practice called patients to encourage them to attend, reminded patients via pop up alerts on the computer system and opportunistically encouraged patients to attend for screening. The practice also

Good

Are services effective?

(for example, treatment is effective)

encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. Uptake for bowel cancer screening was 81% for the years 2013-2015 and 63% for mammography.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance for 2014/15 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 78%, and at risk groups 71%. These were above national averages of 73% and 52% respectively.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 77% to 100% which were all above CCG averages.
- Childhood immunisation rates for five year olds were mostly above CCG average, with the practice achieving 79% for 2013/14 and 95% for 2014/15 for the pre-school booster, compared with the CCG average of 70%.
- The measles, mumps and rubella (MMR) first dose by age 3 was 100% for 2014/15 compared with CCG average of 89%.

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 national GP patient survey for 2014, NHS Friends and Family Test (FFT) data from January 2015 to April 2015 and a survey of 35 patients undertaken by the GP in 2014 as part of the GP appraisal process.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the overall experience was rated as good by 91% of patients compared with the clinical commissioning group (CCG) average of 83% and national average of 85%. Seventy seven per cent of respondents reported they would recommend the practice, which was the same as CCG average and similar to the national average at 78%.The practice had positive responses for its satisfaction scores on consultations with doctors and nurses. For example:

- 80% said the GP was good at listening to them compared to the CCG average of 87% and national average of 87%.
- 86% said the GP gave them enough time compared to the CCG average of 84% and national average of 85%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and national average of 92%.
- 90% said the nurse was good at listening to them compared to CCG average of 73% and national average of 79%.
- 85% said the nurse gave them enough time compared to the CCG average of 73% and national average of 80%.
- 98% said they had confidence and trust in the last nurse they saw compared to the CCG average of 79% and national average of 86%.

FFT data over the previous four months showed that on average 95% of patients would recommend the practice. The survey undertaken by the lead GP in 2014 showed that 100% of patients were confident about the care provided by the GP and 100% were happy to see the GP again.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 39 completed cards and 100% of feedback was highly positive about the service experienced. Eight comments provided constructive feedback about the service but were still positive about the service received. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring, understanding and attentive. They said staff treated them with dignity and respect. Some patients commented that they had been at the practice for a number of years as the service provided was exceptional.

A number of patients commented that reception staff were excellent and treated them with due care and attention. Data from the GP patient survey showed that 93% said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

We also spoke with eight patients on the day of our inspection. All patients told us they were extremely satisfied with the care provided by the practice and said their dignity and privacy was respected. A number of patients commented that the follow up provided after hospital treatment was particularly good. We observed on the inspection day that the GP frequently came into the waiting area and spoke with reception staff and greeted patients in the waiting room before their appointment. Patients and staff told us that this was a normal procedure for the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in the treatment room and consultation room so that patients' privacy and dignity was maintained. We noted that the consultation room door was closed during appointments and that conversations taking place 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. All staff had received a comprehensive range of information governance and confidentiality training which were updated yearly, and we saw evidence of this.

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 administrative lead or practice manager.

Good

Are services caring?

There was information in the registration policy and practice leaflet stating the practice's zero tolerance for abusive behaviour. Receptionists told us that they had had previous situations where they and administrative staff had had to diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey 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:

- 79% said the last GP they saw was good at explaining tests and treatments compared to the clinical commissioning group (CCG) average of 84% and national average of 82%.
- 77% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and national average of 75%.
- 76% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 72% and national average of 77%.
- 73% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 62% and national average of 66%.

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 and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also highly positive and aligned with these views. The lead GP showed us a compliment letter from a patient where they were grateful for the GP's swift action and early diagnosis, referring them urgently for hospital treatment which prevented long term complications for the patient.

Staff told us that translation services were available for patients who did not have English as a first language and we saw notices in the reception areas informing patents this service was available. The practice had a large number of patients who were Tamil and the lead GP spoke a number of languages including Tamil, so the practice were able to effectively engage patients in this patient group in decisions about care and treatment. We saw that the practice had an actively used file in the reception area with care plans for the most complex patients, which were agreed with the patients concerned. The reception staff and clinical staff showed us how they referred to these this routinely when patients called the practice to ensure their care plans were followed and preferences were taken into account.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were mainly positive about the emotional support provided by the practice and rated it well in this area. For example:

- 73% said the last GP they spoke to was good at treating them with care and concern compared to the clinical commissioning group (CCG) average of 80% and national average of 83%.
- 76% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 71% and national average of 78%.

However, the patients we spoke with on the day of our inspection and the comment cards we received were overwhelmingly positive about the emotional care and support received by the practice. Patients told us how reception and clinical staff responded compassionately when they needed help and provided support when required. Patient described how the medical and reception staff were understanding and professional, and frequently offered words of comfort. We were given an example where a patient with mental health needs was provided with immediate attention and a home visit by the GP when concerns were raised.

The practice were responsive to emotional needs of carers. Feedback from a patient who was also a carer, explained how the emotional support provided by the practice had helped the family get through a particularly sensitive time. A number of patients commented that after hospitalisation, care and emotional support provided by the practice was exemplary. Staff showed us how they had links with a local hospice and frequently referred patients and families to this service.

Good

Are services caring?

Notices in the patient waiting room, leaflets and information on the practice website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that if families had suffered a bereavement, the GP contacted them. This call was either followed by a patient 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 informed how practice services were delivered. The lead GP regularly attended clinical commissioning group (CCG) neighbourhood meetings where local population needs and services were discussed and we saw minutes of these meetings. The demographic of the practice population highlighted that 56% had a long standing health condition compared with clinical commissioning group (CCG) average of 49% and national average of 45%. The practice population were mainly English speaking patients, but 24% registered were of Sri Lankan origin and only spoke Tamil and Singhalese.

The practice had signed up to the enhanced service for avoiding unplanned admissions to hospital and implemented care plans to support those patients with complex needs and long standing health conditions. The practice also worked collaboratively with the local neighbourhood GP practices to improve co-ordinated care and self-management for a number of long term conditions. All practice staff, including receptionists were aware of these patients and their care plans. Copies of the care plans were available electronically and kept in a folder which were accessible to all staff, so that when patients called the practice, their information was readily available. The practice had a policy whereby all these at risk patients were contacted within an hour by the GP for a telephone consultation and were given a subsequent appointment where indicated. Staff discussed numerous examples where the care plans had been referred to, to ensure patient needs were responded to appropriately. This demonstrated that practice staff understood and knew their patients in detail.

The practice recognised that they were unable to provide enough access to a practice nurse to meet patient demand, as reflected in some comments we received. We were told that the practice were unable to recruit a part time practice nurse, due to local demand. The GPs had a flexible approach to this and provided nursing services on a day to day basis to ensure patient needs were met. For example, we saw the GP respond to a patient for an urgent request to change dressings during the inspection. We also noted during the inspection that the practice had an open approach with new patients registering, by fully informing them that they were only able to offer appointments with a male GP and they did not have a permanent practice nurse. Patients were directed to another practice in the local CCG for cervical screening and family planning if their needs could not be met by the practice nurse resource.

The practice used NHS Friends and Family Test data and results from the national GP patient survey to inform how services were planned. The practice did not currently have an active Patient Participation Group (PPG), although we saw evidence they had started to promote this in March 2015. The practice told us they had significant problems recruiting members due to language barriers. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.)

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and long term conditions. The practice had a number of patients who were of Tamil origin, and the lead GP was able to speak a number of languages and provide longer appointments. There was also access to telephone translation services if they were needed. However, we noted during the inspection that there was no information or signage in the practice in languages other than English.

The practice knew their population group well and kept registers of those that may need further support, such as vulnerable groups, those at risk of admission to hospital, patients with learning disabilities and patients with a caring responsibility. Staff told us that patients who were homeless were able to register with the practice if required. We saw during the inspection how the reception staff signposted a patient to local services, where they had complex needs.

Reception staff were familiar with the practice policy to prioritise specific patient groups for appointments, such as children and those with complex needs deemed at risk of hospital admission. Staff discussed an example where a patient on the mental health register and who had an unplanned admissions care plan was seen for an

Good

Are services responsive to people's needs?

(for example, to feedback?)

emergency home visit as a priority. We were also told how the reception staff and GPs acted immediately when an unwell child was brought into the practice, where the family were unable to speak English.

Access to the premises and services had been designed to meet the needs of people with disabilities via a wheelchair accessible ramp. The practice was accessible to patients with mobility difficulties as patient facilities were all on one level. The consulting rooms was accessible for patients with mobility difficulties and there was access to disabled toilet facilities. However, the waiting area was relatively small and corridors were narrow which limited access for disabled patients and those with restricted mobility.

Access to the service

The practice reception and telephone lines were open from 8am-6.30pm, Monday to Friday. Appointments were offered from 8.30am-12pm and 4.00pm-6.30pm Monday, Wednesday, Thursday and Friday and 8.30am-12pm and 4.00pm-7.30pm on Tuesdays. The practice was signed up to the extended hours enhanced service and offered extended appointment times on a Tuesday evening from 6.30pm to 7.30pm.

The practice was closed at weekends. Home visits for housebound patients and telephone consultations were offered between 1pm and 4pm. The practice was closed one afternoon every two months due to protected learning time for practice staff.

Routine appointments during the morning and afternoon sessions were available pre-bookable in advance as well as one third of appointments being held for same day emergency appointments. Practice staff told us that routine pre-bookable appointments were normally available four weeks ahead if needed, but frequently they booked routine patients two days ahead. The practice operated a system whereby patients could telephone for an emergency appointment on the day and they would be triaged by the GP on the telephone. Patients most at risk who were on care plans received a one hour call back. Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions.

Where patients were requesting routine appointments a few days ahead and none were available, the reception staff kept a list of these patients so if there was a cancellation they brought the patient's appointment forward, making best use of resources and meeting people's needs. We saw an example of this during the inspection and the patient was very grateful to the practice team for contacting them.

The practice normally accommodated all emergency patients, however they were able to direct patients to the local walk in centre open from 8am-8pm if necessary. The practice had opted out of providing out-of-hours (OOH) services to their own patients and directed patients to the out-of-hours provider. If patients called the practice when it was closed, an answerphone message gave the out-of-hours service information to patients.

Appointments were pre-booked with a locum practice nurse who attended one day a month for cervical screening, long term conditions health checks and childhood and travel immunisations. The GPs also provided immunisations and long term conditions health checks. The practice directed patients to utilise services at another local GP practice for family planning and cervical screening where required. The practice website contained comprehensive information about the practice and information regarding health conditions and local services. Online appointment booking was available.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 83% were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) average of 75% and national average of 76%.
- 93% described their experience of making an appointment as good compared to the CCG average of 70% and national average of 74%.
- 85% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61% and national average of 65%.
- 94% said they could get through easily to the surgery by phone compared to the CCG average of 65% and national average of 72%.
- 99% said the last appointment they got was convenient, compared to CCG average of 90% and national average of 92%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. We spoke with patients who had booked emergency appointments

Good

Are services responsive to people's needs?

(for example, to feedback?)

and they confirmed they had no difficulty securing an appointment. CQC comments cards we reviewed mostly felt that the appointment system worked well, as appointments could be obtained at short notice, including for children. Some patients commented that they would prefer more availability of appointments with a practice nurse.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures had been updated and were in line with recognised guidance and contractual obligations for GPs in England. The administrative lead supported the lead GP to handle all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information was displayed on the website, in the practice leaflet and posters were displayed in the waiting area. 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.

The practice had not received many written complaints; they had received one in the last 12 months. We reviewed this complaint and found that it was acknowledged in a timely way, written communications were thorough, open and transparent. The complaint had not been fully resolved and was being dealt with by the Parliamentary and Health Service Ombudsman and we saw evidence of this.

The practice handled a number of verbal concerns in the reception area that did not result in formal complaints, however they did not keep a log of these to assist in detecting potential complaint themes or trends. Complaints were discussed at practice meetings where 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 had a clear vision to deliver high quality care in a primary care setting and promote good outcomes for patients; to ensure patients are treated with dignity and respect at all times and to establish a professional and caring relationship between the practice staff and the patient. We found details of the vision and values in the practice's statement of purpose. All staff we spoke with were able to articulate that patient care was a priority for the practice, especially for end of life care patients.

The practice did not have a business plan or strategy in place, however the GPs and practice manager discussed strategic direction informally and shared this in staff meeting where necessary. The staff were able to discuss the plans for the practice with us during the inspection.

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 10 of these policies and procedures and they were all reviewed annually and were up to date, apart from the infection control policy which had last been updated in 2008. Policies we saw included adult and children's safeguarding policies, the chaperoning policy, health and safety policies and the policy for significant events.

There was a clear leadership structure with named members of staff in lead roles. For example, the lead GP led in all clinical areas. The administrative lead was the named person for day to day management concerns in the practice and the locum practice manager who visited every two weeks supported this role and ensured governance arrangements were in place to support the practice. 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 GP and administrative lead with support from the practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). Although QOF data was discussed during clinical meetings between the two GPs and opportunistically with the management team, these discussions were not documented. However the staff we spoke with were able to discuss their roles in using QOF to measure performance. The latest QOF achievement was 95% for 2014/15 which was above the local clinical commissioning group (CCG) average.

The practice also attended monthly CCG neighbourhood meetings where performance data was routinely discussed and we saw minutes of these meetings. The practice made use of a range of online resources and tools to gather performance and benchmarking data and we were shown the systems they used to do this.

The practice did not have a planned or on-going programme of clinical audits documented, however there were audits that the practice had undertaken which were specific to the practice population including the diabetes audit, avoiding unplanned admissions audit for children under 16 and those adults with care plans, which it used to monitor quality and systems to identify where action should be taken. These audits resulted in a positive impact for patients, but the audit information was not documented and captured in a way to clearly demonstrate this.

The practice were aware from patient and staff feedback that they had lack of access to a practice nurse. However, they had acted on this and had liaised with the CCG to advertise locally for a part time practice nurse. We were told that there was a shortage of practice nurses within the area. The practice told us that from review of demand and capacity, and with financial implications for the practice taken into account, they planned to increase locum cover to ensure patients' needs were met.

The practice identified, recorded and managed a range of risks. It had carried out a number of risk assessments internally and by use of external companies, where risks had been identified, for example in relation to the premises requiring updating. However the infection control and waste management audits had not identified concerns

Are services well-led?

Good

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

related to the out dated infection control policy, lack of infection control training for all staff and lack of Hepatitis B status for non-clinical staff who were handling clinical waste and assisting with sharps disposal.

The practice held staff meetings every two months where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks were documented.

The practice were well organised in relation to information governance and confidentiality. All staff received a range of training annually following a training needs analysis to ensure role specific training for handling and storage of practice information.

The practice manager was responsible for human resource policies and procedures which were updated annually. The staff handbook was easily accessible to staff on the shared drive and contained policies such as whistleblowing, annual leave, disciplinary and flexible working. New staff had induction checklists completed in their files. Recruitment checks were not fully aligned to national standards, however the practice had robust systems in place to ensure locums had adequate skills and checks completed prior to working with practice patients.

Leadership, openness and transparency

The lead GP was consistently visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. We saw during the inspection that they engaged with the reception team frequently. We saw that there was a culture of collective leadership in the practice which resulted in a well-managed practice. Staff had clear roles and responsibilities, the practice ran smoothly and any concerns were addressed immediately. All staff were involved in discussions about how to develop the practice: the lead GP encouraged all members of staff to identify opportunities to improve the service delivered.

We saw from minutes that team meetings were held every two months but staff were informed of any new developments on a daily basis. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at any time and felt confident in doing so and felt supported if they did. A number of staff had been employed at the practice for a number of years. All staff felt motivated and enjoyed the team approach that the practice encouraged.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the lead GPs patient satisfaction survey in 2014. The practice had received a number of compliments but had not received many complaints. Complaints were frequently verbal and were diffused and resolved quickly, however the practice did not have a way to capture verbal complaints to identify patient feedback through this.

The Patient Participation Group (PPG) was set up in March 2015, and they had had one formal meeting but there were four active members and the practice were finding it difficult to recruit to this group. We were told this was due to language barriers. As such, the PPG had not yet carried out any surveys or been utilised to gather feedback to improve services offered by the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.) We found that three patients we spoke to on the inspection day reported they had not heard of the PPG and would consider joining. The practice website did not advertise the PPG; however it did have a comments facility to encourage feedback.

The practice had completed the NHS Friends and Family Test for the last six months and were gathering feedback to assist in improving the practice; however patients had provided limited additional comments. The practice gathered feedback from staff in staff meetings and day to day discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

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 manager frequently cascaded relevant training course information to staff. Staff told us that the practice was very supportive of training. We looked at five staff files, with three being employed for some time and saw that appraisals had last taken place in 2012. We were told that regular appraisal discussions took place, but not all this information was captured. The GPs had annual

Are services well-led?

Good

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

appraisals and also attended learning sessions with the clinical commissioning group, as well as attending a yearly GP update course. The GPs had close links with peers within the GP neighbourhood for peer support.

Evidence from other sources, including incidents was used to identify areas where improvements could be made, and we saw a number of instances where the practice had raised quality alerts to cascade patient safety information to other organisations that were implicated in incidents.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found that the registered person did not do all that was reasonably practicable to mitigate risks to health and safety of service users as they did not have adequate access to emergency equipment. The registered person did not have adequate systems in place in accordance with infection prevention and control guidance. This was in breach of regulation 12(1)(2)(b)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: We found that the registered person did not ensure that non-clinical staff had the necessary training and checks to be undertaking chaperoning duties. This was in breach of regulation 19(1)(b)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.