Dr KV Reddy

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 17 June 2015.

Overall, we rated this practice as good.

Specifically, we found the practice to require improvement for providing safe services. The practice was good for providing effective, caring and responsive services, and for being well led.

Our key findings were as follows:

- Staff generally understood the process to report incidents, and there was some evidence of learning and discussion around incidents. However not all incidents were fully recorded, and learning was not shared widely. Staff awareness of incidents varied, and we could not always verify whether actions had been taken as a result of an incident.
- Risk assessments relating to the safe running of the practice were not always monitored and reviewed.
- The practice provided a good standard of care, led by current best practice guidelines. Care and outcomes for patients was not always audited fully.
- Patients told us they were treated with dignity and respect.
- Patients could access generally appointments without difficulty, and were happy with the telephone and repeat prescribing systems.
- The building had sufficient facilities and equipment to provide effective services.
- The practice had some strategy and objectives for the future, however staff awareness of these varied.

We saw some areas of outstanding practice including:

- Once a month the practice held awareness days for carers to enable them to keep up-to-date with help and advice. The practice worked with a local carer support organisation who held open days within the practice on a quarterly basis.

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- The practice had a buddy system to allow patients who may struggle to access some areas of the service to have one point of contact with a named member of staff, who would assist them with tasks such as making an appointment or ordering medication.

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

Importantly the provider must:

- Ensure systems are in place to assess, monitor and mitigate the risks to patients, staff and visitors to the practice.

The provider should:

• Ensure that 'patients at risk' registers are regularly reviewed and updated.

• Ensure that learning from incident and complaints is fully recorded and cascaded to maximise learning opportunities.

• Ensure that formal governance arrangements are sufficient to fully assess and monitor risks and the quality of the service provision.

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. Staff generally understood the procedures for reporting incidents and felt encouraged to do so. However, we found some incidents within the practice which had not been viewed as such, and were therefore not reported and investigated fully. Due to this under recording, monitoring and reviewing activity was not always fully accurate. Some lessons were learned from incidents, although from records it was not always possible to tell what actions had been taken and what the eventual outcomes were. Lessons were not always communicated widely throughout the practice to allow additional learning opportunities. The practice had assessed some risks to those using or working at the practice but had not subsequently kept these under review, and in particular had not revisited the assessment for dealing with violent patients following an incident.

Safeguarding systems were not always fully embedded, although staff were able to give examples of where they had raised safeguarding concerns and how they had dealt with these. There were sufficient emergency procedures in place to respond appropriately to medical emergencies in the practice. There were sufficient numbers of staff with an appropriate skill mix.

Are services effective?

Good

The practice is rated as good for providing effective services. Quality data showed most patient outcomes were around average for the locality. Where outcomes were below average the practice engaged with the CCG and specialist staff as necessary to monitor and review this. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely, and patient's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles. Clinical staff undertook some audits of care and reflected on patient outcomes, although there was no audit in place for infection rates following minor surgery, which would be expected. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients gave us positive feedback where they stated that they were treated with compassion, dignity and respect, and involved in their

Summary of findings

treatment and care. The practice was accessible. In patient surveys, the practice generally scored highly for satisfaction with their care and treatment, with patients saying they were treated with care and concern, although some patients were less satisfied in how GPs involved them in their treatment. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had an overview of the needs of their local population, and was engaging with the Clinical Commissioning Group (CCG) to secure service improvements. The practice had good facilities and was well equipped to meet patients need. Information was provided to help people make a complaint, although the recording of complaint investigations could be improved. Patients told us it was generally easy to get an appointment, with urgent appointments available the same day.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. There was a leadership structure and staff felt supported by management, although at times were not sure who was the lead role for a particular activity. Leadership at the practice was somewhat reactive following recent partnership changes. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review or were not specifically tailored to reflect the practice. The practice had published aims and objectives within their statement of purpose. Systems in place to monitor quality and identify risk were at times insufficient and not kept under review. The practice had an active Patient Participation Group (PPG) and was able to evidence where changes had been made as a result of PPG and staff feedback.

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. The over 75's had a named GP. The practice carried out dementia screening and memory loss clinics, and worked with an attached Community Psychiatric Nurse (CPN) who worked in clinics alongside the practice. Home visits including to nursing and care homes were carried out by community staff attached to the practice as part of a CCG wide initiative, as well as by the practice's advanced nurse practitioner. The practice held multi-disciplinary meetings to discuss those with chronic conditions or approaching end of life care. Care plans had been produced for those patients deemed at most risk of an unplanned admission to hospital. Information was shared with other services, such as out of hours services and district nurses. Patients with conditions such as dementia, and their families were signposted to local voluntary organisations. Nationally reported data such as the Quality and Outcomes Framework (QOF) showed the practice had outcomes comparable to the average for conditions commonly found in older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes and asthma attended regular nurse clinics to ensure their conditions were monitored, and were involved in making decisions about their care. Attempts were made to contact non-attenders to ensure they had required routine health checks.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place to identify children who may be at risk. For instance, the practice monitored levels of children's vaccinations and attendances at A&E. However the practice did not actively monitor and review which patients were on this list, and the safeguarding lead was unaware of how many children were classified as at risk and when this was last reviewed. Immunisation rates were above average for all standard childhood immunisations. Full post natal and 6 week baby checks were carried out by GPs, and weekly baby clinics were available at the practice premises.

Summary of findings

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 population had been identified, and services adjusted and reviewed accordingly. Routine appointments could be booked in advance, or made online. Repeat prescriptions could be ordered online. Evening appointments were available on Mondays until 8:30 pm to help those who could not access the surgery during core hours. The practice provided NHS health checks for this group including diet and nutrition advice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. Patients or their carers were able to request longer or home appointments if needed. The practice had a register for looked after or otherwise vulnerable children. However these registers were not regularly monitored and reviewed, and GPs were unaware how many patients were on them. There was no regular programme of safeguarding meetings, although the practice did communicate with the health visitor on an ad hoc basis as required .The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. The practice hosted carers awareness days once a month and worked with a local carer support organisation. All carers and nursing homes had been invited to join the Patient Participation Group (PPG).

Patients were able to access a named member of staff to support them in accessing services such as help with booking appointments or repeat prescriptions. There was some mixed awareness amongst staff around their responsibilities in reporting and documenting safeguarding concerns, and who the safeguarding lead for the practice was.

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). Nationally reviewed data showed the practice carried out additional health checks and monitoring for those experiencing a mental health problem. The practice made referrals to other local mental health services as required. The practice was assigned those patients who had been removed from other practice lists due to violent or aggressive behaviour, and staff had been given extra conflict

resolution training as they aimed to provide a full service to these patients. The practice worked with the mental health team and local drug and alcohol service who attended at the practice one day a week and also gave advice about benefits and employment.	

Summary of findings

What people who use the service say

In the latest NHS England GP Patient Survey of 127 responses, 92% reported their overall experience as good or very good (above the national average at 85.7%).

Areas patients were less satisfied with included: 70% said the GP was good at involving them in decisions about their care (below the CCG average of 86%), and 78% said the GP was good or very good at listening to them (below the CCG average of 90%).

Patients were satisfied with the access to the service. 96% said it was easy to get through on the phone (above the CCG average of 80%), 91% said they were fairly or very satisfied with the GP opening hours (above the CCG average of 79%).

The practice participated in the Friends and Family Test. The latest results supplied indicated that 90% of 88 respondents were likely or extremely likely to recommend the practice to others.

We spoke to four members of the Patient Participation Group (PPG) and five patients during the inspection. We also collected 44 comment cards which were sent to the practice before the inspection, for patients to complete.

The majority of patients we spoke with and the comment cards indicated they were satisfied with the service provided. Patients said they were treated with dignity, respect and care, and that staff including reception staff were thorough, professional and approachable. Patients said they were confident with the care provided, and would recommend the practice to friends and family. A small amount of negative feedback was received around choice of doctors and a lack of female doctors.

Areas for improvement

Action the service MUST take to improve

- Ensure systems are in place to assess, monitor and mitigate the risks to patients, staff and visitors to the practice.

Action the service SHOULD take to improve

- Ensure that 'patients at risk' registers are regularly reviewed and updated.
- Ensure that learning from incidents and complaints is fully recorded and cascaded to maximise learning opportunities.
  - Ensure that formal governance arrangements are sufficient to fully assess and monitor risks and the quality of the service provision.

Outstanding practice

- Once a month the practice held awareness days for carers to enable them to keep up-to-date with help and advice. The practice worked with a local carer support organisation who held open days within the practice on a quarterly basis.
- The practice had a buddy system to allow patients who may struggle to access some areas of the service to have one point of contact with a named member of staff, who would assist them with tasks such as making an appointment or ordering medication.

Dr KV Reddy

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr KV Reddy

Dr KV Reddy (Deneside Medical Centre) provides general medical services (GMS) to approximately 4,700 patients in the catchment area of Seaham and surrounding villages, which is the Durham Dales, Easington and Sedgefield Clinical Commissioning Group (CCG) area.

There are two GP partners, both male. There is a team of two nurse practitioners, one practice nurse and two healthcare assistants. They are supported by a team of management, reception and administrative staff.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; surgical procedures; family planning; maternity and midwifery services; and treatment of disease, disorder and injury. The practice has higher levels of deprivation compared to the England average. There are higher levels of people aged 65 and above, and more people with a long term health condition, or claiming disability living allowance than the England average.

The practice has opted out of providing Out of Hours services, which patients access through the 111 service. The practice is a member of the South Durham Health CIC Federation.

Why we carried out this inspection

We carried out the inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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

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)

Detailed findings

- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection.

We carried out an announced inspection on 17 June 2015.

We reviewed all areas of the surgery, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with management staff, GP's, nursing and clinical staff, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Requires improvement

Are services safe?

Our findings

Safe Track Record

Prior to inspection the practice gave us a summary of significant events from the previous 12 months. The practice had a system in place for reporting, recording and monitoring significant events, and reported incidents electronically to the Clinical Commissioning Group (CCG). Staff we spoke with knew how to access the forms, and felt encouraged to report incidents. However we did find that awareness amongst staff varied as to when to classify an event as an incident. We found evidence from different sources including discussions with staff, complaints and team meeting minutes, three events within the practice that had not been viewed as incidents and therefore not reported as such. This meant that while the practice was reporting the majority of incidents correctly, they were not able to demonstrate fully that the practice had been safe over time due to under recording.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. From our discussions we found GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed in team meetings, and some learning points documented. However it was not always clear whether action had been taken, who was responsible for any action, and whether all incidents had been fully reflected upon. Information was not then cascaded widely to enable all learning opportunities to be taken, with some staff unaware that there had been any incidents. Learning points were shared with staff directly involved through meeting minutes or feedback via email or verbally.

We could see from a summary of significant events that where necessary the practice had communicated with patients affected to offer a full explanation and apology. National patient safety alerts were disseminated by email. Staff were able to give recent examples of alerts and how they had assessed these.

Reliable safety systems and processes including safeguarding

Staff were able to describe types of abuse and scenarios where abuse could be occurring, and how to report these. The practice had a GP safeguarding lead, however staff understanding of who this was varied. This person did not work full time so there was some confusion around who staff would go when the lead was not there. Staff had been trained in safeguarding at a level appropriate to their role with one GP awaiting Level 3 training to deputise as safeguarding lead.

The computerised patient plans were used to enter codes to flag up issues to alert GPs where a patient may be vulnerable or at risk. However this at risk register was not actively reviewed or monitored, and staff were unsure of the numbers of patients classified as at risk and when this had last been reviewed. There was no regular programme of multi-disciplinary safeguarding meetings, instead GPs told us these were held on an ad hoc basis as required. The practice did meet regularly with health visitors and midwives, although much of this was informal and not recorded. We did see some examples where the practice had liaised with other agencies in response to concerns.

Practice staff had access to up to date national child protection and vulnerable adult policies, but no practice policies covering how patients were added to the at risk register, how this was reviewed, and frequency of meeting with clinical teams including health visitors and social services.

The practice had chaperone guidelines, and there was information on this service for patients in reception.

Medicines Management

We checked medicines in the treatment rooms and found they were stored securely and were only accessible to authorised staff. We checked medicines in the fridges and found these were stored appropriately. Daily checks took place to make sure refrigerated medicines were kept at the correct temperature, and procedures were in place in case of a fridge breakdown. Refrigerated and emergency medicines we checked were in date and there was a process for checking. We were not able to check the contents of one doctors bag as this was not available. Another doctors bag did not contain any emergency medicines, although the GP had access to medications at

the practice which he would take to visit if he thought he needed. There was no written risk assessment for the process of whether to carry emergency medications in GP bags and if so which they should be.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had protocols in place for repeat prescribing and medication reviews. The practice reviewed its prescribing data through clinical audits and communication with the CCG, and had audited, for example, antibiotic use.

Prescriptions were stored securely, however there was no auditable system in place to track prescription batch numbers in and out of the practice.

Any changes in medication guidance were communicated to clinical staff. They were able to describe an example of a recent alert. This helped to ensure staff were aware of any changes and patients received the best treatment for their condition.

Cleanliness & Infection Control

Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had infection prevention and control (IPC) and waste disposal policies, and these had been reviewed. There was an identified IPC lead, although some staff were unclear as to who this was. A full infection control audit had recently been carried out, however it was not obvious from this whether some actions had been carried out or when.

We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas, as was hand sanitizer and safe hand washing guidance.

Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice were in place, with daily, monthly and six monthly tasks. These were checked regularly for completeness .The practice employed its own cleaners.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw other equipment such as blood pressure monitors used in the practice were clean.

We saw evidence that staff had their immunisation status for Hepatitis B checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Equipment

We found that equipment such as scales, fridges, spirometers, and oxygen were checked and calibrated yearly by an external company. Contracts were in place for checks of equipment such as fire extinguishers, and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were overseen by the practice manager.

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment. Any faults reported were normally resolved quickly.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us they could work flexibly to cover when needed, for instance through being multi-skilled in dual roles such as

admin/reception. Staff said that although busy, there were generally sufficient staff numbers for the effective operation of the practice. The practice was currently recruiting for an additional salaried GP.

Monitoring Safety & Responding to Risk

The practice had assessed some risks and kept others reviewed. For instance the electrical system had been checked, Legionella testing had been carried out, and management staff carried out a monthly health and safety walk-through of the building. This was not recorded however, so there was no evidence that all risks were being identified on a regular basis. The practice did keep maintenance records of work done such as gas safety checks. A fire safety risk assessment was in place, and regular checks of the system took place.

Some written risk assessments were in place, such as for use of the car park, lone working procedures, infection control risks and unattended prescriptions. However for the most part these had not been reviewed for a number of years and management staff were not immediately aware of their existence.

The practice was responsible for the care of all patients within the CCG area who had been removed from practice lists elsewhere due to violent and aggressive behaviour. The practice had carried out some informal risk assessment and actions, such as installing glass partitions in reception; however they did not have a full written risk assessment for this activity which was regularly reviewed and updated. In particular, we found one incident recorded within practice meeting minutes which could have resulted in injury to staff members, other patients or visiting contractors. Following this incident, it was not recorded whether any actions had been taken to mitigate the risk of a similar incident. Therefore the practice had not fully recognised, assessed or managed the risks associated with anticipated events.

Patients with a change in their condition or new diagnosis were reviewed appropriately and discussed at clinical meetings, which allowed clinicians to monitor treatment and adjust according to risk. Information on such patients was made available electronically to out of hours providers so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

We saw records confirming staff had received Cardio Pulmonary Resuscitation training. Staff who used the defibrillator were regularly trained to ensure they remained competent in its use. This helped to ensure they could respond appropriately if patients experienced a cardiac arrest. Staff could generally describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose, although there was some variation in levels of awareness amongst staff.

A business continuity plan and emergency procedures were in place, which included details of scenarios they may be needed in, such as loss of data or utilities. Weekly fire alarm checks took place and fire drills every six months.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. There was also a defibrillator, oxygen and a nebuliser available. However there was no protocol in place for the use of the nebuliser, for instance detailing indications for use, and safety procedures. Processes were in place to check emergency medicines were within their expiry date.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. They were able to demonstrate how these were received into their practice and disseminated via the computer system as assigned tasks, or via email.

Treatment was considered in line with evidence based best practice. Nursing staff told us they met with GPs once a month to discuss clinical matters. GPs interviewed were aware of their professional responsibilities to maintain their knowledge. Chronic disease nurses had qualifications in all the clinical areas, allowing patients to be seen for multiple conditions while maintaining specialist areas of interest.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates which were kept under review, and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. The practice had recall systems in place to contact patients who had missed appointments to discuss their long-term conditions. The practice worked with attached specialist staff, such as chronic heart disease and diabetes specialist nurses to help enable the practice in meeting patient's needs. The practice participated in initiatives run by the CCG and the Federation to identify the most vulnerable patients and assess their needs to avoid admissions to hospital. The practice worked to the 'KITE' (Keep Improving the Experience) standard for those patients requiring palliative care, which involved proactively planning their care within a multidisciplinary team.

The practice provided annual reviews to check the health of patients with learning disabilities and mental illness. Home visits were available to patients with learning disabilities were needed.

The practice had identified their 2% of most vulnerable patients, who were at risk of an unplanned admission to hospital, and had produced care plans for them. These were regularly reviewed and discussed, for instance after an admission, to ensure they were accurate and addressed the needs of those patients. The practice aimed to deliver a multidisciplinary package of care for these patients. Home visits including to nursing and care homes were carried out by community staff attached to the practice as part of a CCG wide initiative. The advanced nurse practitioner also carried out nursing home visits.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

The practice was responsible for those patients who had been removed from other practice lists due to violent or aggressive behaviour, and ensured that an effective needs assessment took place for these patients without discrimination. Staff had been given extra in-house conflict resolution training as they aimed to provide a full service to these patients.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook some clinical audits. Latest QOF data from 2013-14 showed the practice had an overall rating of 91.7%, slightly below the England average. Staff told us they discussed QOF results in clinical meetings and were kept up to date of whether the practice was on course to achieve or whether there were areas which needed to improve.

The practice carried out some clinical audits, examples of which included antibiotic prescribing. External audits had been carried out on stroke prevention and chronic obstructive pulmonary disease (COPD) treatments. However the subjects chosen for audit were generally led by the CCG, rather than in response to a specific assessment of the needs of the practice population. Audits did not always include a date for future re-audit to gauge the success of any changes made. We did find that although the practice carried out minor operations, there was no audit in place to monitor infection rates.

The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. We saw minutes of meetings where clinical complaints were discussed and the outcomes and practise analysed, to see whether they could have been improved. We saw where GPs had reflected on their practice, for instance on their consultation style following a patient complaint.

Good

Are services effective?

(for example, treatment is effective)

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For instance the practice looked at referral or prescribing data and compared these against criteria, then looked to see how patient outcomes could be improved. The practice had a high identified rate of admissions to hospital due to respiratory problems, and was engaging with the CCG and specialist respiratory nurse to review this.

Clinical staff checked that routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued. Similarly when patients needed to attend for routine checks related to their long term condition.

Effective staffing

Staff told us the practice was supportive of relevant professional development, and could access courses relevant to their role as required. Staff were also able to access protected learning time (PLT) monthly through the CCG. We saw that the mandatory training for clinical staff included safeguarding and infection control. Staff were up-to-date with mandatory training, or in some cases had required training booked.

We saw evidence that all GPs had undertaken annual external appraisals. Continuing Professional Development for nurses was monitored as part of the appraisals process, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice.

We saw evidence that clinical and non-clinical staff had yearly appraisals, which identified individual learning needs and action points from these. On starting, staff commenced an induction including health and safety, overview of the practice and staff policies and procedures, in addition to further role specific induction training and shadowing of other members of staff. New staff members were provided with a mentor or buddy for the first six months of employment. We did find there was no locum induction pack, although the practice told us they used a regular locum, who was familiar with the practice.

Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support. They gave examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure.

Working with colleagues and other services

The practice had recently started fortnightly clinical meetings, where GPs and practice nurses worked with Advanced Nurse Practitioners employed by the local Federation, who visited patients in Nursing Homes and those who were recently discharged from hospital, to try to decrease hospital admissions. There were clear arrangements for referrals to other services using the NHS online referral service and for following up patients who had been referred to other services. This included for following up patients who had been discharged from hospital. Staff were able to give examples of the referral process, such as referring a newly diagnosed diabetic to the dietician.

The practice worked to the KITE standard for those patients requiring palliative care, which involved meetings with a multidisciplinary team including Macmillan nurses, district nurses, physiotherapists and occupational therapists.

Regular clinical and non-clinical staff meetings took place and staff described the communication within the practice as generally good. The practice manager and nursing staff were able to attend forums each month held in the CCG area which allowed sharing of best practice and information.

Blood results, discharge letters and information from out of hours providers was generally received electronically and disseminated straight to the relevant doctor, or where necessary a procedure for scanning documents was in place. There was a system to ensure scanned documents were not sent to a doctor who was on leave. The GP recorded their actions around results or arranged to see the patient as clinically necessary. The practice was participating in a 111 pilot, whereby the 111 service had access to a small amount of appointments daily which they could book directly.

Information Sharing

Good

Are services effective?

(for example, treatment is effective)

All the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practices patient record system and the practice intranet system. This included care and risk assessments, care plans, case notes and test results.

Information was shared between staff at the practice by a variety of means, such as alerts, practice intranet and computer tasks. Practice staff participated in a variety of internal and external management and clinical meetings. Information on unplanned admissions was collated from multi-disciplinary meetings and fed back to the CCG to identify themes and trends.

Referrals were completed using an electronic system, and these were completed where possible at the time the patient attended. There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate.

Consent to care and treatment

We found that staff had received some training around the Mental Capacity Act 2005 within other subjects such as safeguarding and dementia awareness. Staff were generally able to describe key aspects of the legislation and how they would deal with issues around consent, although staff were sometimes unclear on how they would deal with scenarios presented to them involving young people. Further information was available for staff on the practice intranet.

There was a practice policy on consent and mental capacity to support staff and staff knew how to access this. Staff were able to discuss the carer's role and decision making process. Patients were supported to make decisions. Where a patients' mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patients' capacity and, where appropriate, recorded the outcome of the assessment.

Verbal consent was documented on the computer as part of a consultation, and staff were able to explain how they would discuss a procedure, detailing risks and benefits. Written consent forms were used for invasive procedures such as ear syringing or coil fitting, which detailed risks, benefits and potential complications, this allowed patients to make an informed choice.

Health Promotion & Prevention

The practice offered all new patients an assessment of past medical history, care needs and assessment of risk. Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. Patients over the age of 75 had been allocated a named GP. Nurses used chronic disease management clinics to promote healthy living and ill-health prevention in relation to the person's condition.

Patients aged 40-75 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. Rates for childhood immunisations generally higher than the CCG average, and parents could access weekly baby clinics held at the practice. The practice had carried out some promotional work aimed at teenagers, around immunisations and sexual health.

The practice's performance for cervical smear uptake was comparable to the CCG and England average. There was a policy to follow up patients who did not attend for cervical smears and the practice audited rates for patients who did not attend.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke to four members of the Patient Participation Group (PPG) and five patients during the inspection. We also collected 44 comment cards which were sent to the practice before the inspection, for patients to complete. Feedback from all these sources was generally very positive, with patients saying they found the clinicians professional and caring. Some patients commented that they found reception staff caring and helpful, and would go out of their way to help people.

The practice had been named Buddy system in place for patients who may otherwise struggle to access some aspects of the service, such as ordering repeat prescriptions. This enabled these patients to have a consistent point of contact. Patient coding was used on the records to flag up to reception staff when someone may require extra support.

In the latest NHS England GP Patient Survey of 127 responses, 92% reported their overall experience as good or very good (above the national average at 85.7%). However patients were less satisfied in some area is, for instance 78% said the GP was good or very good at listening to them (below the CCG average of 90%).

Calls to the practice came into a separate office away from the reception desk which helped keep patient information private. There was a room available where patients could request to speak with a receptionist in private if necessary. We observed that reception staff were friendly, relaxed and helpful, and maintained confidentiality as far as possible.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Although some consulting rooms had a separate room for examinations, we did find that curtains were not used in treatment and consulting rooms where there was no separate area. Staff we spoke with were mindful of maintaining patients' privacy and dignity as the patient got undressed, for instance turning their backs or looking at the computer while the patient got changed. However this did not afford the same level of privacy as allowing patients to get dressed and undressed behind a curtain.

There was a chaperone policy and guidelines for staff, and a poster advertising the service in reception. Nursing or clinical staff acted as chaperones where requested.

Care planning and involvement in decisions about care and treatment

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. Nursing staff provided examples of where they had discussed care planning and supported patients to make choices about their treatment, for instance the decision of diabetic patients whether to start taking insulin, or use of inhalers for respiratory conditions. Extra time was given during appointments where possible to allow for this.

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. They said they 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 positive and aligned with these views, although feedback from the latest NHS England GP Patient Survey of 127 responses was slightly less positive. 70% of patients said the GP was good at involving them in decisions about their care (below the CCG average of 86%).

Patients said the GPs explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care. Staff told us there was a translation service available for those whose first language was not English, or for sign language interpreters, although staff awareness of these services varied.

Patient/carer support to cope emotionally with care and treatment

The practice kept registers of groups who needed extra support, such as those receiving palliative care and their carers, and patients with mental health issues, so extra support could be provided. The practice held awareness days for patients with Alzheimer's, dementia and their carers. Once a month the practice held awareness days for carers to enable them to keep up-to-date with help and advice. The practice worked with a local carer support

Good

Are services caring?

organisation who held open days within the practice on a quarterly basis. The practice signposted to voluntary organisations such as Dementia UK and Age UK for patients to access additional support.

Patients said they were given good emotional support by the doctors, and were supported to access support service to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service. When patients had suffered bereavement, GPs were notified, and the practice sent a bereavement card and information regarding counselling.

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 generally understood and systems were in place to address identified needs.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area. For instance, the practice had a higher than average identified rate of admissions to hospital due to respiratory problems, and was engaging with the CCG and specialist respiratory nurse to monitor and review this. Longer appointments were made available for those with complex needs, for instance patients with diabetes. Patients could book with a specific GP to enable continuity of care.

The practice monitored those who did not attend for screening or long term condition clinics, and made efforts to follow them up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Extended hours appointments were available on Monday evenings until 8:30 pm which benefitted those patients unable to attend during core hours. Home visits and telephone appointments were available where necessary.

Tackling inequity and promoting equality

The building accommodated the needs of people with disabilities, incorporating features such as level access, automatic doors and level thresholds. Treatment and consulting rooms were on the ground floors. A number of disabled parking spaces were available in the car park outside. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

There was a practice information leaflet available. It covered subjects such as services and clinics available, obtaining test results, and how to book appointments. There was a hearing loop at reception to assist those hard of hearing. Longer appointment times were available for patients with learning disabilities.

The practice had recognised the needs of different groups in the planning of its services. Patient records were coded to flag to GPs when someone was living in vulnerable circumstances or at risk, although there was no overall view of how many people were on this register and when it was last reviewed. There was no female GP for patients to access, however many services could be provided by the female nurse practitioner.

Access to the service

Information was available to patients about appointments on the practice website and patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

Appointments could be made in person, by telephone or online. Repeat prescriptions could be also be ordered online. The practice aimed to see urgent appointments the same day, all other appointments within two days, or patients could also book up to one week in advance, which helped patients to plan. Patients could book up to one month ahead for nurse clinics.

Appointments were available from 8:00am until 6:00pm Tuesday to Friday, with appointments available until 8:30 pm on Monday evenings. Patients we spoke with told us they could generally access appointments without difficulty. There was a practice policy to see any child under five the same day. Opening times and closures were advertised on the practice website, with an explanation of what services were available. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person

Good

Are services responsive to people's needs?

(for example, to feedback?)

who handled all complaints in the practice. Information on how to complain was contained in the patient information leaflet in reception, and staff were able to signpost people to this.

We looked at a summary of complaints made during the previous 12 months. These included a summary of the complaint, learning points and specific actions to be taken. We could see that the complaints had been investigated, however recording of investigations was not always sufficiently robust. We saw one complaint where a patient had been offered a meeting at the practice, but could not find any recording as to whether this happened or not. In another a patient wrote back to say they were not satisfied with some elements of the response, but there was no further details on another response from the practice, for instance signposting the patient to ombudsman details. There was conflicting levels of awareness among GPs on the levels of complaints and which complaints had been recently received.

Patients we spoke with said they would feel comfortable raising a complaint if the need arose. The practice carried out a patient survey in 2013/14. An action plan was then drawn up and agreed with the PPG, with actions such as changing the phone and appointment systems. Results of this survey were available on the practice website. Information on how to make a complaint was available in the practice leaflet, and there was a suggestion box where patients could leave feedback in reception.

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 some aims and objectives in their statement of purpose to improve the health and well-being of patients and prevent future problems. The practice had a published mission statement in their practice leaflet; however staff awareness of this varied.

Management staff had a plan for the future including recruiting an additional salaried GP and succession planning. This was largely reactive due to the breakdown of a previous partnership. It was clear there was some difference in the vision and strategy which the current GP partners wished to develop since the subsequent formation of a new partnership. Staff understanding of the vision and strategy was therefore limited, as were their roles in achieving this.

Governance Arrangements

Staff were generally clear on their roles and responsibilities, and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared computer system. A project was under way to review and update all policies. Policies we looked at such as the chaperone policy, Mental Capacity Act policy and consent policy had been recently reviewed.

There was a leadership structure in place with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding, although staff awareness of GP roles sometimes varied. Division and clarity of lead roles between GPs also needed to be further developed. We looked at minutes from staff meetings and found some evidence that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed the previous year results to be slightly below national average. The practice monitored its results and how to improve, and communicated this to clinical staff. There was a programme of clinical audit, although subjects covered were generally in response to CCG requests rather than following an incident, in response to practice need or from the GP's own reflection of practice. External audits had been carried out on stroke prevention and chronic obstructive pulmonary disease (COPD) treatments. Audits did not always include a date for future re-audit to gauge the success of any changes made. We did find that although the practice carried out minor operations, there was no audit in place to monitor infection rates.

The practice had assessed some risks and kept others reviewed. However for the most part written risk assessments had not been reviewed for a number of years and management staff were not immediately aware of their existence. Staff told us a monthly health and safety walk-through of the building was carried out where some risks were identified, however this was not recorded so this was not possible to verify.

Leadership, openness and transparency

Staff we spoke with felt respected, valued and supported. They felt they were able to raise concerns without fear of retribution. They said there was an open door policy and no blame culture in the practice. Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service and good standard of care.

Staff said they were supported to access training courses as required, and worked within supportive teams. Many staff members had worked at the practice for a number of years and there was generally low turnover. Staff said they generally felt kept up-to-date and involved through team meetings and e-mails.

Practice seeks and acts on feedback from users, public and staff

There was an active Patient Participation Group (PPG), which met quarterly. Annual patient survey reports and action plans were published on the practice website for the practice population to read. The action plan for 2015/16 included introduction of telephone triage, increasing the diversity of the group and increased care home involvement. The practice was actively advertising to recruit to the group to ensure it was representative of the practice population. All carers and nursing homes had been contacted and invited to join the Patient Participation Group.

Are services well-led?

Good

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

We saw some examples where the practice had made changes following patient feedback, for instance staff had carried out extra training in autism, learning disabilities and dementia. Action plans completed from the patient survey included a date for completion.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings. Staff told us they generally felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistleblowing policy which was available to all staff.

Management lead through learning & improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to access protected learning time where necessary. We saw that appraisals took place where staff could identify learning objectives and training needs.

We did find that outcomes and learning from incident and complaints were not always communicated widely meaning some opportunities for learning and improvements were missed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not sufficiently assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17 (2) (b)**