

Drs Seehra Lockyer Davis and Tanoë

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

Requires improvement 

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?

Requires improvement 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Drs Seehra, Lockyer, Davis and Tanoe on 22 October 2014. The inspection team was led by a CQC inspector and included a GP specialist advisor and a practice management specialist advisor.

Overall the practice is rated as requires improvement. Specifically, we found the practice to require improvement for providing safe and well led services. It was good for providing a caring, effective and responsive service. The concerns which led to these ratings apply to everyone using the practice.

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

- Drs Seehra, Lockyer, Davis and Tanoe are a caring practice with doctors who provide a high level of personal care to a large patient population. Each patient has a named doctor. The staff are very committed to acting in the best interests of the patients.

- Patients were satisfied with the service. They felt they were treated with dignity, care and respect and were involved in decisions about their care and treatment.

- The needs of the practice population were understood and services were offered to meet the needs of each patient group. The practice was proactive in helping mothers and babies in need of support. The practice ensured that patients in vulnerable circumstances could access relevant healthcare. Arrangements were in place to make sure that patients' health was regularly monitored.

The areas where the provider must make improvements are:

- Ensure that all incidents and significant events are reported in line with the National Patient Safety Agency's (NPSA) Reporting and Learning System (RLS) and improve their approach to monitoring significant events and incidents.

Summary of findings

- Take reasonable steps to ensure that service users are safeguarded against the risks of abuse by ensuring their records identify the risks to children that the practice have been informed of.
- Implement an effective operation of systems to regularly assess and monitor the quality of the services provided.

In addition the practice should:

- Make information available to patients attending the surgery about their right to a chaperone service.
- Ensure that training records include all the training planned for all staff.

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?

The practice is rated as requiring improvement. Staff had not fulfilled their responsibility to report a significant event. Information about safeguarding was not always recorded to ensure that staff could protect patients from the risk of abuse.

The practice employed adequate numbers of suitable staff to keep people safe.

Requires improvement



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and routinely used. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles although further training needs had not always been identified and planned. The practice had carried out annual appraisals and identified the personal development plans for all staff. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice highly in all aspects of care. Feedback from patients about their care and treatment was consistently positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice 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 an accessible complaints system with evidence demonstrating that the practice listened and responded quickly to issues raised.

Good



Are services well-led?

The practice is rated as requiring improvement for well-led. The practice had a clear vision and strategy to deliver good care to patients. Staff were clear about this vision and their responsibilities

Requires improvement



Summary of findings

in relation to this. The practice had a number of policies and procedures to govern activity, although there was scope to improve systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients. Staff had received inductions, supervision and annual performance reviews. Staff meetings and staff events were not regular and were not available for all practice staff.

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

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments. The provider was rated as good for caring overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and appropriate referral protocols were in place for patients whose health suddenly deteriorated. When needed, longer appointments and home visits were available. Annual reviews of patients with long term conditions included their health and medication needs. 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. The provider was rated as good for caring overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying children living in disadvantaged circumstances and who were at risk, although a more proactive approach to safeguarding children should be adopted by the practice. Immunisation rates were appropriate for all standard childhood immunisations.

Patients told us that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with examples of joint working with a local mother and baby unit, midwives, health visitors and school nurses. The provider was rated as good for caring

Good



Summary of findings

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

Working age people (including those recently retired and students)

The practice is rated as good for the population group of working-age people. 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, as well as a full range of health promotion and screening which reflects the needs for this age group. The provider was rated as good for caring overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people living in vulnerable circumstances. The practice held a register of patients living in vulnerable circumstances including homeless people and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and these patients had received a follow-up reminder to attend their appointments. The practice offered longer appointments for people with learning disabilities. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had also sign-posted vulnerable patients to social services and to various third sector support organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and were aware of their responsibilities to report any concerns to the relevant agencies. The provider was rated as good for caring overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health, including people with dementia.

Good



Summary of findings

90% of people experiencing poor mental health had received an annual physical health check. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had a system in place to follow up on patients who might have a mental health need and had attended accident and emergency or out of hours services.

The practice had in place advance care planning for patients with dementia. Patients were sign-posted to various appropriate support groups and third sector organisations. The provider was rated as good for caring overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection who varied in age and mobility. We spoke with a parent and with four patients who had a long term condition. They all informed us that staff were especially polite and helpful. They said that they were happy with the standards of care they received and had been involved in

making decisions about their care and treatment. Several patients informed us that they would recommend the practice and that they put a high value on the personal care and attention given by the doctors and nurses.

We collected 28 CQC patient comment cards that we had left for patients to choose to complete. All of these comments were positive. Patients described the staff as friendly and caring.

Areas for improvement

Action the service **MUST** take to improve

- Ensure that all incidents and significant events are reported in line with the National Patient Safety Agency's (NPSA) Reporting and Learning System (RLS) and improve their approach to monitoring significant events and incidents.
- The registered provider must take reasonable steps to ensure that service users are safeguarded against the risks of abuse by ensuring their records identify the risks to children that the practice have been informed of.

- The practice must have an effective operation of systems to regularly assess and monitor the quality of the services provided.

Action the service **SHOULD** take to improve

- The practice should make information available to patients attending the surgery about their right to a chaperone service.
- Training records should include all the training planned for all staff.

Drs Seehra Lockyer Davis and Tanoe

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Drs Seehra Lockyer Davis and Tanoe

Drs Seehra, Lockyer, Davis and Tanoe provide primary medical services from their surgery in Lowestoft. The practice has a registered list of approximately 11,570 patients. The practice team consists of four full time male GP partners and five female nurses whose combined hours are equivalent to 3.5 whole time nurse staff. There is also a healthcare assistant. There is a practice manager and a team of administrative and reception staff.

The practice has a Primary Medical Services (PMS) contract with NHS England. The PMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice does not provide an out-of-hours service, but has an alternative arrangement for patients to be seen when the practice is closed.

Why we carried out this inspection

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

comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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

Detailed findings

- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 October 2014. During our visit we spoke with a range of

staff including two GPs, two nurses, the practice manager and reception and administrative staff. We spoke with patients and family members who used the service and observed how people were being cared for.. We reviewed a range of policies and protocols and care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Our preparation included discussions with the NHS England Area Team and the Clinical Commissioning Group (CCG) and local Healthwatch.

Are services safe?

Our findings

Safe Track Record

We found the practice did not have a clear policy for reporting, recording and monitoring significant events, incidents and accidents. Staff informed us that if they needed to report an incident there were incident forms to complete on the practice intranet. They told us that once completed they were sent to the practice manager. The practice manager explained that the system was for these incidents to be managed by the partner GPs.

A GP told us there was not a regular schedule for reviewing incidents or events, but they would be discussed at the GPs' clinical meetings whenever any significant event occurred. We were informed by a GP that no dissemination of these events had taken place and no learning points had been relayed to staff. We reviewed a list of nine reported events. We found these had occurred over the previous five months, although there was no record of when they had been discussed, or what the learning outcomes had been.

We were informed by several staff about an incident that had occurred the day prior to our inspection. The incident had been witnessed by clinical and non-clinical staff. The event had not been recorded or reported as a significant event in line with the requirements of the National Patient Safety Agency's (NPSA) Reporting and Learning System (RLS). The practice manager and a senior partner informed us that this would be reported.

Learning and improvement from safety incidents

The practice did not have a clear system in place for shared learning from significant events. We saw that significant events had been discussed at clinical meetings by GPs, but nurses were not included in these meetings. There was no evidence to show that learning had taken place or that the findings from significant events were disseminated to all practice staff. We saw evidence that complaints had been discussed at staff meetings, although it was unclear whether these discussions had been used to drive improvements to patient safety. We saw one example of this when a GP offered a patient an explanation about their condition. The explanation suggested that this might have been a clinical learning point for clinical staff, but there was no record of dissemination taking place.

National patient safety alerts were disseminated by paper to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to their areas of responsibility. Staff told us they had used this as learning and informed their practice colleagues.

Reliable safety systems and processes including safeguarding

There was scope to improve the system to manage and review risks to vulnerable children, young people and adults. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.. We found that children who had been identified to be at risk and those who were on a child protection plan were shown as an alert on the practice's computer system. We found that records for children at risk were inconsistent and incomplete. Risks were not recorded and so it was not clear how staff could best protect each child.

Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. 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. They were aware of how to contact the relevant agencies should this be necessary and these contact details were easily accessible to clinical staff.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children. All staff we spoke to were aware who these leads were and who to speak to in the practice, if they had a safeguarding concern.

Medicines Management

We checked the medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and within specific temperatures and were only accessible to authorised staff.

Processes were also in place to check that medicines were within their expiry date and were suitable for use. All the medicines, including emergency medicines that we checked, were within their expiry dates.

All prescriptions were reviewed and signed by a GP before they were given to patients. Blank prescription forms were handled in accordance with national guidance and were kept securely.

Are services safe?

We saw records of practice meetings that noted the actions taken in response to reviews of prescribing data. We saw that prescribing patterns for sedatives and anti-psychotic drugs had been reviewed.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were maintained. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a nurse lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and annual updates.

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

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

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 a criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice manager told us how the practice was dedicated to ensuring they had enough numbers of staff to provide an appropriate level of care to patients. They told us they had tried to recruit an additional GP but had not been able to do so. We were shown figures that showed that the practice patient population had a net growth of slightly more than 1,000 patients during the previous two years. The practice had arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement for the regular use of two locum GPs. The nurse team and the administrative staff covered their colleagues' annual leave. At the time of our inspection, the practice had just appointed an additional advanced nurse practitioner. However, a GP and the practice nurse informed us there was a ratio of approximately 2,600 patient per GP and that additional clinical staff had been difficult to recruit.

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

Monitoring Safety & Responding to Risk

The practice had processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see. We found that there were emergency processes in place for identifying acutely ill children. We were shown examples where expectant mothers had been identified as requiring support for parenting skills or where lifestyles were a risk to an unborn child. Emergency processes were in place to deal with pregnancy complications. Staff gave examples of how they

Are services safe?

responded to patients experiencing a mental illness, including supporting them to access emergency care and treatment and mental health services. We were informed by the lead GP that all the GPs in the practice monitored repeat prescribing for people receiving medication for mental health needs and had assessed the risks of their homeless patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks had been identified for power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We saw minutes of clinical meetings where new guidelines were disseminated and discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed assessments of patients' needs in line with NICE guidelines,

The GPs confirmed they lead in specialist clinical areas such as diabetes and heart disease and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with said that they could openly request support from and give advice to their colleagues.

The practice used computer programmes to identify patients with complex needs and who had multidisciplinary care plans documented in their case notes. Appropriate protocols were in place to follow up and review the care needs for patients who were recently discharged from hospital. We saw evidence that practice staff worked in a multidisciplinary way to meet the needs of patients experiencing heightened risks during pregnancy. National data showed that the practice's referral rates to secondary care were similar to the national average for all health conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancer. We saw no evidence of discrimination when making care and treatment decisions

Management, monitoring and improving outcomes for people

The practice did not have a formal policy approach to conducting audits, although staff had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and reviewing QOF performance in terms of outcomes for patients. There was no evidence to show how GPs had evaluated the service or documented any ensuing changes. There was no evidence available to indicate whether the practice was using audits and clinical supervision to assess

the performance of clinical staff. The nursing staff we spoke with discussed how, as a team, they reflected upon the outcomes being achieved and areas where they could improve their performance.

The practice had undertaken three audits within the last year. Two brief audits for obesity and cancer had been conducted in 2013 and September 2014 respectively. The cancer audit showed that codes for specific treatment had not always been recorded by the practice and this had been addressed. The obesity audit was used to inform a pre-diabetes audit that followed in 2014 and which was continuing at the time of this inspection.

The practice was not an outlier for any QOF clinical targets. They had used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 89% of patients with diabetes had an annual medication review, and the practice also met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease).

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question.

Effective staffing

The practice employed medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that these records were not completed for all staff and that it was unclear what training was required by the practice. However, staff informed us they had recently undertaken mandatory basic life support training and safeguarding training. GPs had a date for their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had received an annual appraisal which identified learning needs from which action plans were documented.

Are services effective?

(for example, treatment is effective)

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties, for example, the administration of vaccines. Those with extended roles such as seeing patients with asthma and diabetes were able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs, patients who were nearing the end of their lives and expectant mothers who were at risk. These meetings and contacts involved district nurses, social workers, palliative care nurses. Decisions about care planning for people near end of life were documented in a shared care record.

Information Sharing

The practice was not proactive in obtaining information about children who had been identified in the practice records as at risk. For instance, records showed which children were at risk but there was no information where this information had come from or what risk there was. The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The software enabled paper communications, such as letters from hospitals, to be scanned and saved in the system for future reference.

Consent to care and treatment

We found that staff had a basic awareness of the Mental Capacity Act 2005 and of the Children's and Families Act 2014 and their duties in fulfilling it. Staff were able to describe how they applied the principles around mental capacity. A consent policy was in place, although this did not refer to how the practice staff should consider determining mental capacity. The policy highlighted how patients should be supported to make their own decisions.

We saw that 'do not attempt resuscitation' orders had been implemented and had reflected patients' decisions about resuscitation. These had been saved as electronic records in the medical notes.

Patients with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed when changes in clinical circumstances dictated this and contained a section stating the patient's preferences for treatment and decisions relating to resuscitation. Clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the risks and benefits of the procedure.

Health Promotion & Prevention

Health promotion literature was readily available to patients. This included information about services to support them in smoking cessation schemes. Patients were

Are services effective?

(for example, treatment is effective)

encouraged to take an interest in their health and to take action to improve and maintain it and were encouraged to attend weight reduction clinics and smoking cessation sessions.

We saw that new patients were invited into the surgery when they first registered to find out details of their past

medical and family health histories. They were also asked about social factors including occupation and lifestyle and medications. This enabled the clinicians to assess new patients' risk factors.

Carers could be referred to external carer support organisations that could provide additional practical and emotional support.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the data available for the practice on patient satisfaction. This included information from the national patient survey. This evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated among the best for patient satisfaction on consultations with doctors and nurses.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 28 comment cards and all of these were positive about the service experienced. Patients said the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. There were no negative comments made. We also spoke with nine patients on the day of our inspection. They all told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. A

system had been introduced to allow only one patient at a time to approach the reception desk which prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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. Data from the national patient survey showed 90% of practice respondents felt that their GP involved them in care decisions. The results from the practice's own satisfaction survey showed that 95% of patients said they were sufficiently involved in making decisions about their care.

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 positive and aligned with these views. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor the service to meet their needs. We were shown the measures the provider had taken to identify patients with diabetes and asthma and other long term conditions and to ensure that they accessed regular reviews.

The practice had responded positively to meet patients' needs. Mothers and parents in need of support or known to be at risk had been identified. We saw that some of these patients had been treated as emergency temporary patients who were immediately registered with the practice because they had moved as temporary residents to the areas whilst living in a temporary residential accommodation whilst being assessed for their parenting skills. We found that patients with learning disabilities or mental health conditions were offered an annual health review.

Homeless patients had regularly been seen by the practice doctors and provided with temporary registration with the practice. Patients aged 85 and over were offered annual health checks. The practice nurses visited housebound patients in their homes to review their care needs and to offer flu vaccinations. The patient information leaflet informed us that all adults were encouraged to have an annual health check.

Tackle inequity and promote equality

The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The practice operated an open list so that patients who were temporarily resident in the area could register as a temporary resident.

The practice premises were purpose built. There was easy access for patients with restricted mobility. There were accessible toilet facilities and corridors were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor.

Patients we spoke with did not express any concerns about their rights or how they were treated by staff.

Access to the service

Mothers and parents in need of support or at risk had good access to healthcare and support from the practice. We spoke to one mother who told us that they had found it easy to make an appointment and were confident they could access a doctor or a nurse for an urgent or routine appointment. Reception staff told us children would always be seen on the day an appointment was requested.

Appointments were available each weekday mornings and afternoons from 8am until 6:30pm.

Comprehensive information was available to patients about appointments on the practice website and in the practice 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. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns and complaints

The practice had responded to complaints and we saw evidence that the practice had provided patients with full explanations of the issues they had brought to the attention of the practice.

We read a list of six complaints made to the practice since June 2014. We saw these had been reviewed by the partner GPs either individually, or collectively, depending on the subject of the complaint. For instance, we saw that a complaint relating to a delayed heart condition diagnosis had been investigated by all of the partner GPs. However, this complaint was not included as a significant event and no learning had been identified as a result. No learning points had been identified from the other five complaints either.

Are services well-led?

(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 and promote good outcomes for patients. The practice's visions and values that were stated in their charter included the aim to provide the best possible service to patients. The practice manager and staff we spoke with articulated the values of the practice. All were confident and knowledgeable when discussing dignity, respect and equality. From speaking with the practice manager and other staff the importance of provision of quality care was evident.

We were informed by a senior partner that the practice had been trying to recruit at least one additional GP after a GP partner had retired. The senior partner informed us that their vision had been adapted as the practice had faced a significant turnover of patients and had seen their patient list increase by over 1,000 during the previous two years. As a result they had refocused on employing an additional nurse, alongside additional administrative resource to support the increased number of patients leaving and joining the practice. We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The governance arrangements at the practice required some improvement. It has been referred to in the effective domain of this report that there was no evidence to demonstrate how the practice evaluated the service or was using clinical supervision and staff meetings to assess the performance of clinical staff. It was not clear who was responsible for monitoring and developing systems to ensure that patients received a consistent level of high quality care. For example, there was no overall clinical leader with an overview of the performance of the practice although there were identified lead roles for areas such as, safeguarding, infection control and complaints.

The governance arrangements for overseeing a robust review of and learning from significant events and complaints require improvement. Brief audits for obesity and cancer had been conducted in 2012-2013 and September 2014 respectively. The audit cycles were not

complete, although tangible improvements were evident. There was scope to expand the clinical audit programme undertaken by the practice in order to deliver better outcomes for patients.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly clinical meetings. No action plans were made to show whether action was necessary to maintain or improve outcomes. There was no evidence that there were arrangements for identifying, recording and managing risks, apart from risks of fire and loss of electrical power and loss of premises. We were informed by a GP and the practice manager that currently each of the four GPs managed approximately 2,600 patients and that this was a large workload. There was no risk assessment relating to the increase in patients due to nearby practices closing their patient lists and the retirement of one GP, despite the practices' acknowledgement of the need to employ more staff.

Leadership, openness and transparency

We were shown a leadership structure which had 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. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Some staff told us how they would like more support and contact with GPs and a more inclusive team approach to practice meetings.

We found evidence that leadership by example could be improved, for example there was scope to expand and embed learning from managing incidents and reviewing significant events. Increased openness and transparency across the practice staff team would foster a culture of reporting and improvement.

We found there was daily monitoring of the patient appointment system to ensure the system was accessible and responsive to patient needs. This information had been made available to patients and to the patient participation group. Patients who repeatedly failed to attend appointments were identified and written to advising them of the importance of attending appointments.

Are services well-led?

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

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

The practice had a Patient Participation Group (PPG). The PPG is a forum made up of patient representatives and staff who discuss changes within the practice and how services could be improved for patients. There was no information on the practice website informing patients about the group. There were reports and action plans from PPG surveys that had been conducted and acted on by the practice.

The practice had invited patients to make comments, complete a questionnaire and provide feedback. The results from the most recent survey, which was carried out in 2013-2014 were published on the practice website along with an action plan. The survey showed that the majority of patients were satisfied with the care and treatment that they received and how they were treated by staff. The majority of less positive comments received related to appointments.

Some of the patients we spoke with told us that they were aware of the PPG although most were not. Those who were not part of this group told us that they were always listened to by staff at the practice.

Management lead through learning & improvement

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

The practice had completed reviews of significant events and other incidents but had not shared them with staff via meetings to ensure the practice improved outcomes for patients. This has been referred to elsewhere in this report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse
(1)(a)(b) The registered provider had not made suitable arrangements to ensure that service users are safeguarded against the risks of abuse.
This was because records did not identify the risks to children that the practice had been informed of.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
9 (1)(b) The practice had not reflected published guidance issued by an appropriate professional body.
This was because the practice had not ensured that guidance issued by National Patient Safety Agency (NPSA) for reporting significant events or incidents was followed.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers
1 (a)(b) The practice did not have an effective operation of systems to regularly assess and monitor the quality of the services provided.