

Dr Harminderjeet Surdhar

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Harminderjeet Surdhar's Practice, Fiveways Health Centre on 24 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all necessary employment checks for all staff including any locum GPs or nursing staff who work at the practice.

Summary of findings

- Ensure that sufficient numbers of staff are on duty including cover arrangements when practice nurse or health care assistants are on leave.

In addition the provider should:

- Ensure that the GP completes the necessary training to obtain a level 3 qualification in the safeguarding of vulnerable adults.
- Implement systems to ensure that staff are aware that the vaccine fridge should not be unplugged.
- Implement systems to ensure clinical waste is stored securely and not accessible to patients or other visitors to the practice.
- Ensure that all portable electrical appliances are routinely tested and display stickers indicating the last testing date.
- Ensure that systems are in place to ensure staff receive updates regarding best practice and clinical guidelines
- Implement a system for logging, investigating and acting upon verbal complaints received at the practice.

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 requires improvement for providing safe services as there were areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, the practice could not demonstrate that sufficient pre-employment checks had been undertaken on locum staff who worked at the practice. When the practice nurse and health care assistant were on leave, the practice did not use locum staff and appointments were either cancelled or moved. Clinical waste was stored in a room which was accessible to patients and other visitors to the service, and there was no evidence of electrical testing undertaken on some portable electrical appliances seen.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or slightly above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. We were told that NICE guidance was discussed at staff meetings although we did not see any evidence to demonstrate this. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and multidisciplinary meetings were held on a monthly basis.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with clinical commissioning group and national averages for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. Extended opening hours were provided one evening per week and the practice opened at 8am two mornings per week.

The practice had an active patient participation group (PPG) which worked together with practice staff to make changes to improve services and gather patient opinion regarding the service offered. A PPG is a way in which patients and GP practices can work together to improve the quality of the service.

Good



Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings.

Good



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. Vaccination programmes were available, for example influenza and shingles. The practice was in line with national averages in all patient categories for influenza vaccination uptake. Patients at higher risk of admission to hospital were identified and offered care plans and review under the unplanned admissions enhanced service. A local enhanced service had been introduced to identify patients aged over 75 years who were at higher risk of admission or clinical deterioration but did not fall under the unplanned admission enhanced service. The practice held a register of housebound patients to ensure reviews were booked for home visits. Multi-disciplinary team meetings were held every month and representatives from the practice clinical team, community matrons, district nurses and case manager's team attended.

Elderly patients with long term conditions had care plans in place and regular reviews took place. Hospital and accident and emergency (A&E) attendance was monitored to enable the GP to make contact following discharge to ensure that there has been no change to health needs.

The GP attended a local care home twice per week which helped to ensure that patients received consistent care from a named GP. We were told that when required, end of life care planning was completed according to the patient's wishes.

Good



People with long term conditions

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

87% of medicine reviews undertaken for patients with a long term condition on four or more medicines. Medicine reviews were undertaken within 72 hours of discharge from hospital for patients in this population group. The practice participates in Quality and

Good



Summary of findings

Outcome Framework (QOF) which involved reviewing and monitoring patients with long term conditions/chronic diseases. Records seen demonstrated that the practice was a high QOF achiever.

The GP followed up patients who had been discharged from hospital who resided in a care home and the community matron visited patients in the community and provided feedback to the GP. Care plans were seen for those patients receiving end of life care.

Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Children under the age of five were offered a same day appointment when required. Child health surveillance checks were offered for new born babies. Quarterly meetings were held with the health visitors to address any safeguarding issues.

We saw that the practice promoted chlamydia screening for the young population.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. A health check including cardiovascular risk assessment was available for patients aged between 40-74 years and 75% of patients in this group had undertaken this health check.

Extended opening hours were provided one evening per week and the practice was open at 8am two mornings per week. Telephone consultations were available for those patients who were unable to access the practice during normal working hours.

Good



Summary of findings

The practice provided well man and well women clinics and recorded the smoking status of patients during routine consultations.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances and applied appropriate read codes to patient records. For example children with a protection plan or vulnerable adults. Details of those vulnerable patients were recorded on a board in the office for administrative staff to see. The process of putting a flag on these patients' records had commenced. This flag would be used to alert staff that these patients may have additional needs. Longer appointments were offered for patients with a learning disability and for those with drug and alcohol addiction. A substance misuse clinic was held at the practice twice per week.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

There were no homeless patients registered at the practice. However, we were told that homeless patients were able to register with the practice and the contact telephone number and next of kin details (where possible) would be obtained to enable contact with the patient the patient for health needs review. Patients would also be informed of the Health Exchange service where homeless people and rough sleepers could access primary medical services without an appointment. Staff monitored vulnerable adults or children who attended the accident and emergency department (A&E) frequently or who missed appointments. This information was brought to the GP's attention who arranged appointments or worked with other health care professionals to ensure vulnerable patients' health needs were being met.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 89% of people experiencing poor mental health had received an annual physical health check. Same day appointments were offered to patients to prevent any deterioration in mental health. The practice

Good



Summary of findings

regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Some staff had received training on how to care for people with mental health needs and dementia.

Patients newly diagnosed with dementia would be referred to services such as a memory clinic and given details of external support agencies.

Summary of findings

What people who use the service say

As part of the inspection we sent the practice a comments box and cards so that patients had the opportunity to give us feedback. We received 31 completed comment cards and on the day of our inspection we spoke with two patients. The vast majority of comments received were positive. Patients commented that staff were caring, the GP listened and the service was efficient. One patient was less satisfied and felt that the GP had rushed them during their consultation.

We looked at results of the national GP patient survey carried out in July 2014. Findings of the survey were

based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Areas that were assessed as worse than expected included the percentage of patients who felt that the GP did not give them enough time. Areas in which the practice does best related to the ease of getting through on the phone and patients being able to see their preferred GP. All other results were in line with national averages.

Areas for improvement

Action the service **MUST** take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff including any locum GPs or nursing staff who work at the practice.
- Ensure that sufficient numbers of staff are on duty including cover arrangements when practice nurse or health care assistants are on leave.

Action the service **SHOULD** take to improve

- Ensure that the GP completes the necessary training to obtain a level 3 qualification in the safeguarding of vulnerable adults.

- Implement systems to ensure that staff are aware that the vaccine fridge should not be unplugged.
- Implement systems to ensure clinical waste is stored securely and not accessible to patients or other visitors to the practice.
- Ensure that all portable electrical appliances are routinely tested and display stickers indicating the last testing date.
- Ensure that systems are in place to ensure staff receive updates regarding best practice and clinical guidelines
- Implement a system for logging, investigating and acting upon verbal complaints received at the practice.

Dr Harminderjeet Surdhar

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 GP specialist advisor and a practice manager specialist advisor with experience of primary care services.

Background to Dr Harminderjeet Surdhar

Dr Harminderjeet Surdhar's Medical Practice is located in the Fiveways Health Centre and in the NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). The practice provides primary medical services to approximately 4,100 patients in the local community under a general medical services (GMS) contract. We reviewed the most recent data available to us from Public Health England which showed that the practice is located in one of most deprived areas in the country. The population served is younger than the national average.

The lead GP at the Dr Surdhar's Medical Practice is male, and a female locum GP also works regularly at this practice. A practice manager, practice nurse (female), health care assistant (female) and five administrative staff also work at the practice.

The practice opening times are from 8.30am to 6.30pm on Tuesday and Friday and from 8am to 6.30pm on Thursday. Extended opening hours are provided from 8am until 7.30pm on Mondays and the practice is closed from 1pm onwards on a Wednesday afternoon.

The practice manager told us that when the practice was closed on a Wednesday afternoon, general medical service

cover was provided by Badger, an out of hours provider. Primecare also provide out of hours cover when the surgery is closed in the evening. Primecare are the out of hours service contracted by the CCG.

We previously inspected the Dr Surdhar's Medical practice on 4 August 2014 and found that improvements were required in some areas generally relating to governance arrangements, particularly relating to assessing and monitoring the quality of service provision and effective systems to manage risk. Other areas requiring attention were incident reporting, emergency equipment, mental capacity act, management of prescriptions, infection control, alert systems on patient records, review of policies and procedures, staff appraisal and complaints. These areas were reviewed as part of this comprehensive inspection.

Why we carried out this inspection

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

We previously inspected Dr Surdhar's Medical practice on 4 August 2014 and found that improvements were required. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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

Before inspecting we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We carried out an announced visit on 24 March 2015. During our visit we spoke with a range of staff including a GP, nurse, practice manager and administrative staff and we spoke with patients who used the service. We also spent some time observing how staff interacted with patients. This practice had an active patient participation group (PPG). PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of care.

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
- 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

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

Staff spoken with were aware of their responsibilities to raise concerns and knew how to report and record significant events. Staff said that they were happy to raise issues as they occurred and confirmed that these were discussed at practice meetings. Staff were aware of recent incidents such as a patient being issued with an incorrect medicine.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of seven significant events that had occurred during the last 12 months and saw this system was followed appropriately. Policies were available on the computer to guide staff of the action to take in the event of an incident or near miss. These policies had been reviewed within the last 12 months. Staff had undertaken E-learning regarding events and incidents and staff spoken with were confident about their role in reporting and recording significant events.

Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with staff who attended the meetings. However, we were told that the GP did not attend all practice meetings. Attendance at these meetings by the GP would help to ensure that staff understood the significant event and learning outcomes.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the

meetings and they felt encouraged to do so. Staff used incident forms on the practice intranet and sent completed forms to the practice manager who showed us the system used to manage and monitor incidents. We tracked seven incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, incorrect patient details were input on a blood test form sent to the hospital. We saw that an investigation had taken place, the event discussed during a practice meeting and the practice policy for blood sample collection amended to reflect the importance of cross checking patient details before performing the procedure. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were received by the practice manager and discussed with the GP before being sent to all practice staff if applicable. Alerts that were relevant to the practice were discussed at practice meetings to ensure all staff were aware of where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Safeguarding vulnerable adults and children procedures were available to all staff on the practice computer. Contact details for external safeguarding agencies were recorded on policies. The lead GP was the appointed lead in safeguarding vulnerable adults and children. Records seen demonstrated that all staff had undertaken safeguarding vulnerable adults and children training. Staff had achieved the basic level training for safeguarding vulnerable adults and the lead GP was working towards achieving a higher level training. We were told that the GP would then undertake the advanced level training. We looked at training records which showed that the lead GP and practice nurse had undertaken the advanced level training in safeguarding children and administrative staff had undertaken this training at the appropriate level. All staff we spoke with were aware who the lead was and who to speak to within the practice if they had a safeguarding concern.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information,

Are services safe?

properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

We were shown a self-evaluation workbook which was being used, for example, to evaluate how well the practice were working towards safeguarding policies and procedures and staff knowledge of safeguarding issues. This was last reviewed in May 2014. Staff also completed a self-assessment of safeguarding knowledge and experience in March 2015.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children with child protection plans, the practice also put a code on the records of parents of a child with a protection plan in place.

Currently there were no adults subject to safeguarding registered at the practice. The GP and staff were aware of the appropriate codes to use on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The GP was in the process of trying to identify adults who were vulnerable, for example those patients who lived alone and those with no family contacts. Staff were in the process of putting a flag on the system to alert staff that these patients may have additional needs.

There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors, district nurses and the local authority. We were told that the GP was invited to attend multi-disciplinary meetings regarding vulnerable adults and children registered at the practice. The minutes of any meetings were forwarded to the practice and information was scanned onto the appropriate patient's records. The GP had recently attended a separate meeting with health visitors to discuss vulnerable children registered at the practice. Agreement had been reached to meet on a quarterly basis.

Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency (A&E) or missed appointments frequently. These were brought to the GP's attention, who then worked with other health and social care professionals. We saw minutes of meetings where

vulnerable patients were discussed. The GP had met with health visitors and meetings were now scheduled to take place on a quarterly basis to discuss those on the practice list who had a child protection plan in place and those who have been removed or moved to another area. Health visitors made further contact with the practice if they had any information to pass on prior to the quarterly meeting.

There was a chaperone poster on display in the waiting room. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The fridge used to store vaccinations was not hard wired and there were no measures in place to prevent the power being switched off by mistake.

We were shown records to demonstrate that stock rotation took place and a log of vaccine batch numbers and expiry dates was available. Records seen showed that the cold chain was maintained, this included keeping records of fridge temperatures to ensure medicines were kept at the appropriate temperature. This was identified as an area for action at our last inspection which had now been addressed. A cold chain policy was in place which had recently been reviewed. The practice had a protocol and guidance for staff recording the action to take in the event of a fridge power failure and staff we spoke with were clear about the action they would take to ensure vaccines were appropriately stored or disposed of. This included the transfer of all vaccines to a local 'buddy practice' who would store the vaccines until the fridge was repaired. However, the health care assistant was unable to show us a suitable container, such as a cool box which would keep

Are services safe?

the vaccines at the required temperature during transfer. We received a copy of a purchase order following our inspection demonstrating that a portable medical cooler had been purchased.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. At our previous inspection of the service this had been identified as an issue. The practice had taken action to address this. There was a protocol for repeat prescribing which was followed in practice. The protocol covered areas such as how changes to patients' repeat medicines were managed and the number of repeat prescriptions authorised. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were all in date. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD. This included a PGD regarding human papilloma virus vaccinations. (HPV). HPV is the name for a group of viruses that affect your skin and the moist membranes lining your body, for example, in your cervix, anus, mouth and throat. This vaccination was offered to all teenage girls via the school nurse at their place of education, but would be given at the practice if requested.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We were told that the practice employed a cleaner for up to 15 hours per week. Cleaning schedules were in place and cleaning records were kept. Control of substances

hazardous to health (COSHH) records were also available for the cleaner. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. For example, the infection control lead had undertaken skills for health and link nurse training and records seen demonstrated that they attended regular updates. Administrative staff had undertaken a course for non-clinical staff regarding infection control.

A detailed infection prevention and control policy was in place and used by staff. This had been reviewed within the last 12 months. We also saw that the practice nurse had developed an incident protocol regarding biological substances. We saw evidence that the lead had carried out an audit recently and that any improvements identified for action were completed.

Infection prevention and control measures in place included the use of personal protective equipment (PPE), clearly labelled sharps bins and spillage kits. Disposable curtain screening was provided as appropriate, these recorded the date for disposal and all seen were within date.

Spillage kits were used to clean up any spillage of blood or bodily fluids such as vomit, urine or other body substances. These spills need to be treated promptly to reduce the potential for spread of infection with other patients, staff or visitors. Staff were aware where spillage kits were stored and when they should be used.

PPE, including disposable gloves, aprons and treatment couch coverings were available for staff to use and staff were able to describe how and when they would use these. Disposable aprons were available to staff from the cleaning cupboard but were not available in the nurse's treatment rooms. Sharps bins seen had been clearly labelled and staff spoken with were aware of when they should be disposed of. 'Sharps' is a medical term for devices with sharp points or edges that can puncture or cut skin such as needles or syringes. Sharps bins were used to safely store used sharps prior to disposal.

Are services safe?

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Hand gel and notices advising patients of the availability of hand gel was available in the reception area.

We discussed the arrangements for managing clinical waste. We saw that there was a policy for management of clinical waste which had been reviewed within the previous 12 months. We saw that clinical waste was stored in large yellow bins in an unlocked room. Therefore clinical waste was not stored securely as patients may have access to clinical waste. We were told that the room was left unlocked as the emergency equipment and medicines were stored in this room. The practice manager confirmed that she would move the emergency equipment and medicine to another location and ensure that the door to the clinical waste storage remained locked when not in use. The health care assistant (HCA) was responsible for emptying the clinical waste bin before removal from the premises by an appropriate contractor.

At the last inspection of the practice in 2014 we identified that the practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). At the inspection we saw a copy of this policy and the associated risk assessment. The legionella risk assessment identified a low risk and the practice manager had decided that the risk was sufficiently low to make formal testing unnecessary.

Equipment

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

The practice manager told us that all portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw two pieces of equipment which had stickers in place which had not been dated. The practice manager did not have a list of equipment to be tested. We saw a document which recorded the number of items that had been portable appliance tested (PAT), stating that no items had failed the test. We were told that equipment would be tested again in June 2015 and the practice manager would list all items to be tested.

We saw evidence of calibration of relevant equipment; for example, baby scales, digital blood pressure monitor and ear syringe. Certificates had been provided for each individual piece of equipment. Stickers in place on equipment identified that the next calibration was due September 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We were told that the practice would benefit from the employment of a secretary and a member of administrative staff had recently resigned. The practice manager confirmed that they would be recruiting for these staff in the near future.

We asked the practice how they ensured there were enough staff on duty to maintain the smooth running of the practice and to keep patients safe. We found the arrangements in place were not adequately robust. The practice manager told us that the administrative staff worked flexibly to cover any sickness or leave. The practice did not have any formal arrangements to cover the practice nurse or health care assistant's annual leave. When the practice nurse and health care assistant were on leave the practice did not use locum staff and appointments were either cancelled or moved. We were told that if the health care assistant (HCA) was off sick this would be covered by a member of reception staff who also worked as a HCA at another practice,

Locum staff would be used to cover any annual leave of the GPs. We were told that a locum agency was used to provide staff. We were not shown a copy of a service level agreement between the agency and the practice. Although an email from the agency recorded details of the information they obtained regarding locum GPs. The practice manager had not obtained suitable pre-employment information such as qualifications, evidence of criminal records check. The practice manager confirmed that they would request copies of this information for all future locum GPs used at the practice. We were told that a nurse from a neighbouring practice had undertaken a cervical screening clinic and was due to complete another clinic in April. This was undertaken to help improve the practice's uptake for cervical screening. However, the practice had not undertaken any employment checks on this nurse such as evidence of registration with professional body, references, criminal

Are services safe?

records checks or evidence of training undertaken. During the inspection the practice manager sent an email to this nurse and requested details of checks on their criminal records, personal identification number (PIN) to demonstrate registration with the appropriate nursing body and their Cervical cytology PIN. The cervical cytology PIN would demonstrate that they had undertaken appropriate training. Following our inspection we were sent copies of the information requested from the nurse.

We looked at four staff personnel files including the file of the staff member most recently employed. Records seen contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, details of work history and criminal records checks via the Disclosure and Barring Service (DBS). One written reference had been obtained for staff. We saw that DBS checks or disclosures regarding criminal records were in place for staff. We saw evidence that the practice nurse had up to date registration with the Nursing and Midwifery Council (NMC), the nurses governing body. All nurses and midwives who practise in the UK must be on the NMC register.

Monitoring safety and responding to risk

At the previous inspection of this practice in August 2014 we found the fire risk assessment was not up to date. At this inspection we saw that an external company who undertook checks of the practice's firefighting and electrical equipment had completed a fire risk assessment in conjunction with the practice manager.

We also saw that various control of substances hazardous to health (COSHH) risk assessments had been completed. For example, regarding photocopying and emissions, sample handling, cleaning activities and the various cleaning products used. The practice had undertaken a COSHH audit which identified the products in use. We saw records to confirm that staff training had been completed and records were available regarding safe storage of products.

A workplace review tool had been completed in October 2014. This was a comprehensive review of, for example, fire systems, personal safety and security, various areas of the practice such as stairways, offices, public areas, heating and ventilation, electrical equipment, use of medical gases, clinical waste, display screen equipment and manual

handling operations. This helped to ensure that the practice had systems and processes in place to manage and monitor risks to patients, staff and visitors to the practice.

Arrangements to deal with emergencies and major incidents

During our previous inspection of the practice we saw that staff had not carried out regular checks of firefighting equipment. Emergency oxygen was out of date and records to demonstrate that checks had been made on emergency medication and equipment were not robust. The business continuity plan had not been fully completed.

During this inspection we noted that the practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether 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 identified included loss of computer or telephone system, power failure, adverse weather, incapacity of staff and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had undertaken a review of their processes regarding responding to a major incident. We were told that the practice manager was in the process of liaising with the clinical commissioning group (CCG) to ensure that they conformed with joint efforts being made across the region to respond to a major emergency.

Are services safe?

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training. We saw that firefighting equipment had been regularly checked and maintained.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GP told us that NICE guidance was downloaded from the website and was discussed during staff meetings. However we did not see evidence of this in the minutes that we reviewed. We were shown a copy of the MIMS guidance used by the GP to enable them to follow national prescribing guidelines. (MIMS is a pharmaceutical prescribing reference guide).

Vulnerable patients, those with long term conditions and patients over 75 years old were assessed and care plans generated to enable increased monitoring and follow up of these at risk patients. The practice had a register of patients with complex mental health needs. Records seen demonstrated that 94% of these patients had care plans agreed and in place and 98% had their alcohol intake recorded; these figures were above the national averages. Staff explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, a specialist diabetic nurse held clinics each week to ensure that patients with diabetes were having organised routine health checks and were being referred to other services when required.

The GP told us they lead in specialist clinical areas such as palliative care and visited a local hospice to see those patients registered at the practice. The GP also visited a local care home twice per week and was supported by a case manager.

Patients with long term conditions had their care reviewed by the GP and a case manager. A case manager is a healthcare professional who provides services to assist patients with complex health conditions to achieve a better quality of life. We saw that the case manager attended monthly multi-disciplinary meetings and in between these meetings would provide updates to the GP regarding patients registered at the practice.

The practice had started a scheme to avoid unplanned hospital admissions by providing an enhanced service. An enhanced service is a service that is provided above the standard general medical service contract (GMS). This

focused on coordinated care for the most vulnerable patients and included emergency health care plans. These patient groups included vulnerable, older patients, patients needing end of life care and patients who were at risk of unplanned admission to hospital. The aim was to avoid admission to hospital by managing their health needs at home. The practice was in the process of introducing a local enhanced service. This identified patients aged over 75 who were at higher risk of admission or clinical deterioration but did not fall under the unplanned admission enhanced service. The GP had been undertaking medicine reviews of patients aged over 75 years who were taking eight medicines or more. A member of practice staff was responsible for monitoring data for all of these patients who had been discharged from hospital.

Emergency admissions for the 19 ambulatory care sensitive conditions were in line with the national average. These are chronic conditions that can be appropriately managed in the primary care setting.

Management, monitoring and improving outcomes for people

At the previous inspection of the practice we were not shown any completed clinical audit cycles. During this inspection the practice showed us five clinical audits that had been undertaken in the last five years. We saw that one of these audits had resulted in a prescribing cost saving since the initial audit. The GPs told us that clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics. Information regarding prescribing data showed that antibiotics prescribing quality was improving regularly for each quarter of the audit. We saw that the results of audits were discussed at practice meetings.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice achieved 98.2% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

Are services effective?

(for example, treatment is effective)

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- The proportion of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was similar to the national average.

The practice nurse delivered the childhood vaccination programmes. The most recent data available to us showed that the practice was below the local CCG rate for some childhood vaccinations. The practice was also below with uptake rates for cervical cytology and currently 69% of eligible patients had undertaken cervical cytology screening in comparison with a national average of 81%. The practice nurse had systems in place to follow up patients who did not attend screening or immunisations. We saw that patients were sent letters and received telephone contact to remind them of the need to visit the practice.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we were told about the action being taken to address these issues. For example an additional cervical screening clinic had been completed and a further clinic was planned.

We were told that Birmingham Healthy Minds counsellors visited the practice each week and patients were able to self-refer to this service. Birmingham Healthy Minds is an NHS primary care psychological therapies service that works closely with Birmingham GPs. BHM offers advice, information and brief psychological talking therapies for people aged 16 and over, who are often feeling anxious, low in mood or depressed.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and

saw that all staff were up to date with attending courses such as annual basic life support, infection control and safeguarding. Although the GP had only attended the basic level training in safeguarding vulnerable adults.

We discussed training with the health care assistant (HCA). We were told that the GP was proactive and encouraged staff to undertake training. The practice manager told us that the practice nurse was very proactive and attended a lot of training courses. We saw copies of training certificates to confirm this. For example the practice nurse had attended training courses regarding spirometry, palliative, chronic complex and end of life care in the community and anticoagulation. We saw that the practice nurse had defined duties that they were expected to perform. Training records seen demonstrated that this staff member was trained to fulfil these duties.

Lack of supervision or appraisal was identified as an issue for action at our last inspection of the practice. During this inspection we discussed the appraisal systems in place and reviewed a random sample of appraisal records. We were told that all staff undertook annual appraisals and staff spoken with confirmed this. We saw that appraisal meetings were conducted by both the practice manager and GP. We saw that learning needs were identified during the appraisal process. Staff confirmed that they had annual appraisal and were able to discuss any work related issues during this process. We were told that the practice was proactive in providing training and funding for relevant courses.

We were told that locum GPs were used at this practice to cover times of sickness or annual leave. Systems in place to ensure that locums used were appropriately qualified and pre-employment checks undertaken were not robust. The practice manager had not obtained information such as qualifications, references or checks of criminal records from the locum agency who supplied these staff. We saw that locums received information about the practice's policies and procedures, computer system, non-urgent referrals and the appointment system.

We were told that the clinical commissioning group (CCG) provided protected learning time (PLT) training twice per year for the GP and practice manager. E learning was available to staff on the practice's computer. We were also told that monthly meetings of practice managers and

Are services effective?

(for example, treatment is effective)

separate meetings of practice nurses were held for those within the CCG area. These meetings were used to provide updates from the CCG and to discuss issues and share learning.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Every two weeks the practice manager made contact with local hospitals and out of hours services to cross check and ensure that all information had been received at the practice. This helped to ensure joint working arrangements were regularly reviewed and effective. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were 12.09% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings on a monthly basis to discuss patients with complex needs. For example, those with multiple long term conditions, people from vulnerable groups and those with end of life care needs. These meetings were attended by district nurses, community matrons; hospice team, case managers and decisions about care planning were documented in a shared care record. Separate meetings were held on a quarterly basis with health visitors to discuss children with protection plans. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

There was a national recall system in place for cytology screening which was carried out by the practice nurse. This ensured women received this important health check including their results in a timely manner.

There were clear and effective arrangements for following up on people who had been referred to other services or for people who had been discharged from hospital. This included the practice manager reviewing discharge summaries on a weekly and those who require were contacted by the GP to follow up with a visit to the practice if required.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice manager told us that monthly practice meetings were held. We saw minutes which confirmed this. However, we noted that the lead GP did not always attend these meetings. We looked at three practice meeting minutes and saw that the GP had not attended these meetings.

There were no formal systems in place to demonstrate that information from these meetings was

disseminated to staff who did not attend. However, the GP told us that the minutes of the meeting were sent to them and they acted upon any clinical information discussed.

The practice manager told us about the arrangements in place for communication with health visitors which included attendance at multi-disciplinary meetings on a quarterly basis. We were told that health visitors attended the practice on a regular basis to collect information

Are services effective?

(for example, treatment is effective)

regarding newly pregnant mothers, newly registered children, details of children who do not attend (DNA) childhood immunisations or any DNA appointments regarding children. This helped to ensure that relevant information was forwarded to the appropriate people such as health visitors for follow up.

Consent to care and treatment

During our last inspection of the practice in 2014 we found that staff had not undertaken training regarding the Mental Capacity Act. Staff spoken with were not able to provide evidence as to how the Act had been implemented and how they had ensured that decisions made on behalf of a patient that lacked capacity were in their best interest.

During this inspection we found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. We saw copies of training certificates which demonstrated that staff had completed training regarding the Mental Capacity Act. We were told that the GP was the lead for mental capacity.

We were told that those patients with a learning disability and those with dementia who lived at the local care home were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually. We were unable to review any care plans that were kept at the local care home.

We spoke with the GP who demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

We were shown an entry recording consent given for a minor surgical procedure; the patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. The practice had not undertaken an audit that confirmed the consent process for minor surgery had been followed.

The GP provided care for some patients at a local nursing home. We were told that where restraint had needed to be used, records were kept in the care plan of the patient. These care plans were kept at the care home. We were told that issues regarding consent had been discussed with care

home staff and patients as applicable. Those patients that required had been allocated an advocate to help them make decisions. Advocate details were recorded in patient care plans.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

For example, the practice actively promoted chlamydia screening, this was particularly important for this practice as they had a larger than average younger age population. Weight management clinics were also provided as well as a range of clinics regarding the management of long term conditions such as diabetes and asthma. The practice nurse offered 20 minute appointments for chronic disease management and systems were in place to ensure that patients regularly received a review of their condition.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The health care assistant completed these checks during a 20 minute appointment. Where risk factors for disease were identified at the health check appointments were scheduled with the GP.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all had been offered an annual physical health check within the last 12 months. The practice nurse was responsible for chronic disease management.

New patient consultations were also offered to newly registered children to support the delivery of the healthy child programme. The healthy child programme is an initiative which, for example encourages care that keeps children healthy and safe and to protect children from serious diseases, through screening and immunisation.

The practice's performance for the cervical screening programme was 69%, which was below the national average of 81%. There was a policy to offer telephone reminders and three letters for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice were aware that they were below the national average for cervical screening and had undertaken an

Are services effective?

(for example, treatment is effective)

additional clinic for cervical screening. A nurse from a local practice worked as a locum. An additional clinic was planned for April to try and ensure that the practice met their cervical screening targets. Information regarding cervical screening was available in the practice waiting area; this information had also been produced in Punjabi.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 73%, and at risk groups 61%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 82% to 95% and five year olds from 71% to 88%. These were comparable to CCG averages.

Health promotion information and leaflets were available in the waiting area. Leaflets regarding chronic disease and health exchange who are a community service that helps people make choices about their lifestyle with the aim of improving their health were available.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the July 2014 national patient survey. The 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 patients who rated the practice as good or very good. The practice was also average for its satisfaction scores on consultations with doctors and nurses. For example:

- 85% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 81% said the GP treated them with care and concern compared to the CCG average of 80% and national average of 85%.
- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%
- 91% said the nurse was good at listening to them compared to the CCG average of 89% and national average of 91%
- 86% said the nurse treated them with care and concern compared to the CCG average of 87% and national average of 90%
- 95% said that they had confidence and trust in the last nurse they saw compared to the CCG average of 95% and national average of 97%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards and the majority were positive about the service experienced. Patients said they felt the practice was safe and clean; staff were friendly, helpful and provided excellent care. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with two patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said that practice staff were kind, friendly and treated patients with respect.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Patients we spoke with on the day of inspection were happy that their confidentiality was maintained and said that reception staff were friendly. Additionally, 90% of respondents to the national GP patient survey said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 75% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 76%.

Patients we spoke with on the day of our inspection told us that the GP was good and all staff were friendly and caring. Patient feedback on the comment cards we received was positive, patients commented that they felt listened to and said that staff were helpful and caring.

Staff told us that translation services were available for patients who did not have English as a first language. We also saw that staff had contact numbers of various external services who could provide support to patients. For example alcoholics anonymous and CRUSE bereavement services.

Patient/carer support to cope emotionally with care and treatment

Are services caring?

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

- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.
- 86% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. Patients who use services were supported to manage their own health, care

and wellbeing by attending chronic disease management clinics undertaken by the practice nurse. The practice held a register of carers and computer systems also alerted staff if a patient was also a carer. This would help the practice to provide the necessary support to the carer, such as support group or health promotion advice. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

We saw evidence that the practice nurse had received end of life training. Staff told us that if families had suffered a bereavement, their usual GP contacted them by letter and/or phone call. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Information regarding CRUSE was sent to patients and was available in the waiting area. CRUSE bereavement care is a support organisation to help people after the death of someone close.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We were told that those patients with mental health needs were offered an appointment on the same day that they telephoned unless they requested an appointment on a different day. People experiencing poor mental health and those with long term conditions were offered longer appointments. Home visits were undertaken to those patients who were unable to attend the practice due to frailty or immobility. Appointments were available outside of school hours for children and young people and patients who work during normal office hours.

The practice told us how it delivered services to meet the needs of its patient population. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and diabetes. There were nurse led services such as the vaccinations, cervical smear tests as well as disease management services which aimed to review patients with common illness and ailments. The practice participated in Over 75s Enhanced Service. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated and were provided with a direct access telephone number. The direct number for the named GP was forwarded to all other organisations involved in the care, for example the out of hours service and ambulance service.

The practice was working towards implementing the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. Special patient notes is information recorded about patients with complex health and social care needs used to alert or highlight any specific care requirements, long term care plans or any other useful information.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example patients had commented that they were not given enough time with the GP during consultations. The practice now identifies

vulnerable patients (those aged over 75, patients with learning disabilities, dementia and multiple co-morbidities) on their computer system and offered these patients a double appointment slot.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, patients with a dementia, alcohol or drug addiction or patients with a mental health illness. Patients had access to online and telephone translation services.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of 'no fixed abode' but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. We were told that next of kin details and contact number (where possible) would be obtained so that regular contact could be made with the patient for health needs review. These patients could also be informed of the Health Exchange Service where homeless people and rough sleepers could access primary medical services without an appointment.

The lead GP was male and a female GP worked at the practice twice per week; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at team events.

Access to the service

Information was available to patients about appointments on the practice website. Other information such as how to arrange telephone consultations was also available.

Are services responsive to people's needs?

(for example, to feedback?)

Reception staff told us that patients were able to book appointments in person at the practice, over the telephone or on-line, although we were told that the uptake for on-line appointments had been low. An interpreting service was available for those patients whose first language was not English. Patients who were hard of hearing used the British Sign Language service and a hearing loop was available at the reception desk.

Patients were able to book an appointment in advance, on the day that they telephoned and emergency appointment slots were available each day. Telephone consultation appointments were available every day and the GP also undertook home visits. We were told that patients with mental health illness, children and those with palliative care needs were seen on the day that they telephoned, unless they requested an appointment on an alternative day. Information on the practice website informed patients that they were able to book double appointments if they had multiple issues to discuss with the GP.

This practice was open between the hours of 8.30am to 6.30pm on Tuesday and Friday and from 8am to 6.30pm on Thursday. The practice closed on a Wednesday afternoon and cover was provided by an out of hours provider who also provided cover when the practice was closed during the evening. Extended opening hours were provided on a Monday from 8am to 7.30pm. Patients unable to attend during normal surgery hours due to work commitments therefore had access to the practice at this time. Patients were also able to contact the GP for telephone advice. This helped those patients with work commitments to have access to the practice.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with palliative care needs. This also included appointments with a named GP or nurse. Home visits were made to a local care home on a specific day each week, by a named GP.

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

- 84% described their experience of making an appointment as good compared to the CCG average of 66% and national average of 74%.

- 73% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 54% and national average of 65%.
- 92% said they could get through easily to the surgery by phone compared to the CCG average of 67% and national average of 74%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, a copy of the complaint procedure was on display in the waiting room and complaints leaflets were available to patients. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received during 2013; we were told that the practice had not received any complaints during 2014. We saw that complaints had been handled effectively and in a timely way, all information about complaints was kept on file. Complainants received a regular update and letters of explanation and apology. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and saw that two complaints related to a delay in being seen for an appointment. This delay was unavoidable due to an emergency and an explanation was given to those patients who had complained. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Although we were told that no complaints were received during 2014/15, information seen demonstrated that verbal complaints had been received and dealt with immediately. The details of the complaints had been recorded in a log. However, there was no evidence of any follow up or outcome recorded. It was therefore difficult to monitor trends during the annual complaints review.

Minutes of practice meetings demonstrated that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice leaflet recorded the practice and patient responsibilities. This included expecting to receive the highest quality medical care and to be treated in a courteous and respectful way at all times. A copy of the practice charter was on display in the waiting area of the practice. The statement of purpose recorded the practice's values and vision. We were told that the practice were working towards being more involved in the community providing health promotion activities.

We spoke with six members of staff who were aware of their roles and responsibilities and how they helped to ensure that a high level of service was provided to patients. Staff told us that they were kept up to date with any changes that were taking place at the practice and open discussions were held at practice meetings.

Staff we spoke with demonstrated an understanding of their areas of responsibility and they took an active role in ensuring that a high level of service was provided. They also told us they felt valued and they were able to contribute to the shaping of the practice for the benefit of patients.

Governance arrangements

The practice manager was the clinical governance lead. We saw evidence that staff had undertaken information governance training. Staff told us that the policies and procedures in place to govern activity were available to them on the desktop on any computer within the practice. All of the policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. (QOF is a voluntary incentive scheme which financially rewards practices for

managing some of the most common long-term conditions and for the implementation of preventative measures). 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 team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an antibiotic prescribing audit. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Areas for improvement regarding governance were identified at our last inspection of the practice in 2014. We found that there was no set agenda for practice meetings and incidents and significant events were not routinely discussed and policies and procedures had not been reviewed. At this inspection we saw that the practice had taken action to address these issues.

Leadership, openness and transparency

The GP and other management at the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The practice manager did not have an office and worked alongside administrative staff. We were told that this worked well.

We saw from minutes that team meetings were held every month. However, the lead GP did not always attend these meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included

Are services well-led?

Good 

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

representatives from various population groups such as working age and older age. The PPG met every quarter. The results and actions agreed from the last PPG survey was available on the practice website. Actions were agreed in conjunction with the PPG. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. We were told that these results were to be discussed with PPG members at their next meeting to agree action plans.

We were told that the practice manager and GP had an 'open door' policy meaning that staff could speak with them at any time. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. The practice manager told us that they would fund any learning considered relevant for the role. We were told that regular practice manager and separate practice nurse meetings were held with staff from other local practices.

This helped staff to learn from each other and pass on areas of good practice. We looked at four staff files and saw that regular appraisals took place which included a personal development plan.

The practice had completed five audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit regarding the prescribing of antibiotics, showed that antibiotics prescribing quality was improving regularly for every quarter. Another audit regarding SIP feeding showed a prescribing cost saving since the initial audit. SIP feeds are prescribable oral nutritional supplements to enhance or provide the complete nutritional requirements for an individual.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, an antibiotic had been prescribed for a patient with the same name as the patient attending the practice. The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example legionella, the premises and control of substances hazardous to health. However some action was required to reduce risks. For example, clinical waste was stored in an unlocked room, evidence of sufficient pre-employment checks had not been obtained for locum staff and when the practice nurse or health care assistant were on leave appointments had to be cancelled or moved.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>How we found the regulation was not being met</p> <p>We found the provider had not undertaken appropriate checks to ensure that persons employed were of good character or had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. The provider had not ensured that the information specified in Schedule 3 was available or that persons employed were registered with the relevant professional body.</p> <p>Regulation 19 (1)(a)(b) (2)(a)(3)(a)(b)(4)(a)(b)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>How we found the regulation was not being met</p> <p>We found the provider had not employed sufficient numbers of suitably qualified, competent, skilled and experienced persons</p> <p>Regulation 18(1)</p>