

Dr Neville Fernandes

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?

Good 

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 Neville Fernandes on 23 August 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and generally well managed. We found two areas of the premises that required minor repair. We also found the practice needed to take action to address the issues raised in the gas safety check and to ensure the lift was maintained at appropriate intervals.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment although they had not had training in

the Mental Capacity Act (MCA) 2005 or the Duty of Candour. With the exception of the GP, staff had a limited knowledge of the MCA 2005, and no knowledge of the Duty of Candour.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and we saw complaints were dealt with promptly. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice had an active patient participation group and acted on its suggestions.
- We found the fire evacuation records; children's safeguarding policy, complaints policy, recruitment files and infection control audit needed updating.

Summary of findings

The areas where the provider should make improvement are:

- Keep recruitment files up to date and ensure they contain the information required in the regulations.
- Keep a record of fire evacuation drills.
- Introduce a quality improvement programme which includes re-auditing to complete the audit cycle.
- Keep under review how best to address (some) patients' preference for a female GP.
- Ensure staff have and maintain an understanding of MCA and Duty of Candour appropriate to their roles.

- Add contact details for external authorities to the safeguarding children policy and review the complaints procedure to make it practice specific.
- Keep records suitable for review and auditing purposes of actions taken in response to audits, risk assessments and safety checks.
- Carry out repairs to the premises.

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 good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. All staff had undergone appropriate training. We found the contact details for external child safeguarding authorities needed to be added to the practice's child safeguarding policy.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy.
- Risks to patients were assessed and generally well managed however we found some repairs were needed to the premises and staff needed to keep records suitable for review and auditing purposes of actions taken in response to audits, risk assessments and safety checks.
- We found appropriate recruitment checks had been undertaken or requested prior to employment, but that essential information had not always been retained in the staff file.
- The practice had adequate arrangements in place to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. The practice had achieved 98% of the total number of points available, compared to the CCG and England average of 95%.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment; however they had not had training in the Mental Capacity Act 2005 and Duty of Candour.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Staff sought patients' consent to care and treatment in line with legislation and guidance. The practice had consent forms for specific areas, including family planning and minor surgery.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Practice results from the national GP patient survey for its satisfaction scores on consultations with GPs and nurses were mixed compared to the CCG and England averages however the results also showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We received 87 comment cards, 81 of which were wholly positive about the practice. Ten patients had made negative comments but they had all also given some positive feedback.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice offered a weekly minor surgery clinic, and accepted referrals from other practices.
- Patients said they found it easy to make an appointment and 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 evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

- Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was to the same or above local and national averages. For example 92% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

Are services well-led?

The practice is rated as good for being well-led.

Good



- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- 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 staff meetings. Staff were aware of their own roles and responsibilities.
- The practice had defined objectives for the forthcoming 12 months. The priority was to recruit a female GP.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements, although only a minority of audits had been completed with a re-audit.
- The GP was aware of the requirements of the duty of candour but other staff were not familiar with the terminology. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Nevertheless staff were able to describe actions they had taken which were in keeping with the duty of candour.
- The GP encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, as a result of suggestions by the PPG the practice had improved the availability of information, including the complaints procedure. It had also extended the walk in clinic hours and improved receptions staff availability at lunchtime.

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.

Good



- 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, and offered home visits, including phlebotomy, and urgent appointments for those with enhanced needs.
- Patients over the age of 75 years had a named GP.
- Holistic health assessments were offered for patients aged over 65. The practice had carried out 61 assessments this year of which 41 had been for housebound patients.
- Housebound patients were discussed at regular meeting with District Nurse.
- Palliative care patients were discussed at regular meeting with the local hospice.
- The practice participated in monthly MDT meetings with the local hospital geriatrician to discuss management of complex patients requiring multidisciplinary service input.
- The practice took part in geriatrician virtual clinics.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, who had had influenza immunisation in the preceding 1 August to 31 March (01/04/2014 to 31/03/2015) was 96% compared to the CCG average of 90% and England average of 94%. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less (01/04/2014 to 31/03/2015) was 90% compared to the CCG average of 74% and England average of 78%.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Patients were referred to a wide range of services to assist them to maintain good health, for example exercise and healthy eating programmes.
- Patient information was regularly updated so that patients were kept informed.
- Virtual clinics with consultants were held regularly to discuss complex patients. In the last year this had included clinics for hypertension, diabetes and atrial fibrillation.
- Clinicians kept abreast of NICE and local CCG guidelines on the management and prescribing of long term conditions. They attended Lambeth CCG training as well as peer group learning, for example joining the Practice Nurse Forum.

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 A&E attendances.
- Young children were given priority in the walk in clinics and also seen urgently when required.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice was proactive in promoting and providing contraception including coil fitting. This service was also provided to non-registered patients.
- The practice offered sexual health testing.
- The practice promoted preventative immunisation, such as MMR catch-up immunisation for young adults who had not previously been immunised.
- The practice worked with the wider primary health care team and allied health professionals such as the health visitors and social services.
- Cancer screening data was mixed compared to CCG and England averages. For example, the number of females, aged 50-70, screened for breast cancer in last 36 months was 58%

Good



Summary of findings

compared to the CCG average of 60% and England average of 72%. The number of females aged 25-64, who whose notes recorded that a cervical screening test has been performed in the preceding 5 years (01/04/2014 to 31/03/2015) was 81% compared to the CCG average of 80% and England average of 82%.

- Child immunisation rates were comparable to or above the CCG averages in all but two areas. The percentage of children aged 24 months who received the Infant Men C immunisation was 67% (CCG average 81%) and those aged 5 years who received the Dtap.IPV Booster was 74% (CCG average 83%).

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 reflects the needs for this age group.
- Extended hours clinics were available including a late night family planning clinic.
- Online booking, electronic prescribing and travel immunisation was offered.
- Sexual health screening was provided and free condoms were available.
- NHS health checks for 40-74 year olds were offered.
- The practice worked with the local GP federation hub which provided 8am-8pm weekday and weekend appointments for patients when the practice had no availability.

Good



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 including homeless people, travellers and those with a learning disability. There were 20 patients on the learning disability register. The practice told us they had all had an annual review in the preceding year, and they were currently working through the list for the current year.

Good



Summary of findings

- The practice offered longer appointments for patients with a learning disability which were compatible with their carer's availability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed 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.
- Vulnerable patients were added to the practice's admissions avoidance register and regularly reviewed.
- The GP had undergone training in alcohol and drug misuse, and the practice hosted a fortnightly clinic with a counsellor.
- Homeless and refugee patients could register with the practice.
- Non-English speakers were offered double appointments with an interpreter.
- The practice works closely with a local food bank and provided food vouchers to vulnerable patients.

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).

- The practice had nine patients on its dementia register. One hundred percent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months (01/04/2014 to 31/03/2015), which was above the CCG average of 88% and national average of 84%.
- The practice had 69 patients on its mental health register. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 97% compared to the CCG average of 85% and England average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.

Good



Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. For example, patients were offered appointments at times to suit them as for some, due to their medication, morning appointments were not practical.
- Dementia assessments were part of the holistic health assessment offered to the over 65 year olds.
- The practice had engaged in the GP+ scheme which enabled patients with mental ill health to be discharged into primary care.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with or better than local and national averages. Four hundred survey forms were distributed and 96 were returned. This represented 3% of the practice's patient list.

- 92% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 79% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 72% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 87 comment cards, 81 of which were wholly positive about the standard of care received. Patients told

us they were treated with dignity and respect and listened to; they received exceptional care from the GP; staff were caring and helpful and they would recommend the practice to family and friends. Ten of the comment cards contained both positive and negative feedback. The negative comments related predominantly to waiting times and difficulty in getting appointments.

We spoke with six patients during the inspection, including three members of the Patient Participation Group. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. One commented that they were not always told what their medicines were for. The only issue raised by the PPG was the lack of a permanent female GP.

The practice told us they reviewed feedback from the Friends and Family test monthly. They selected one negative comment each month (if there was one) to analyse and they sent us a copy of this analysis. Four of the eight concerns reviewed related to availability of appointments.

Areas for improvement

Action the service **SHOULD** take to improve

- Keep recruitment files up to date and ensure they contain the information required in the regulations.
- Keep a record of fire evacuation drills.
- Introduce a quality improvement programme which includes re-auditing to complete the audit cycle.
- Keep under review how best to address (some) patients' preference for a female GP.
- Ensure staff have and maintain an understanding of MCA and Duty of Candour appropriate to their roles.
- Add contact details for external authorities to the safeguarding children policy and review the complaints procedure to make it practice specific.
- Keep records suitable for review and auditing purposes of actions taken in response to audits, risk assessments and safety checks.
- Carry out repairs to the premises.

Dr Neville Fernandes

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist adviser and an Expert by Experience.

Background to Dr Neville Fernandes

Dr Neville Fernandes' practice provided services to approximately 3100 patients in the Norwood area of south east London under a Personal Medical Services contract (an agreement between NHS England and general practices for delivering personal medical services). It sits within the Lambeth clinical commissioning group (CCG) which has 48 member practices serving a registered patient population of more than 380,000. Dr Fernandes' practice provides a number of enhanced services including timely diagnosis and support for people with dementia; support for patients with a learning disability; minor surgery and remote care monitoring.

The staff team at the practice consists of one full time male GP, a female practice manager, two part time female practice nurses and five administrators/receptionists. The practice provides 13 GP sessions per week. Three of these are provided by a locum GP. The practice told us that wherever possible they try to ensure the locum is female so as to provide patients with a choice. The service is provided from this location only.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 9am to 12pm every morning and 3pm to 6pm every afternoon daily. Extended hours appointments are offered on Thursdays until 7.50pm. Outside of these hours, patients are advised to contact the

practices out of hours provider, whose number is displayed on the practice noticeboard. The practice provides an online appointment booking system and an electronic repeat prescription service. Patients can also view test results online. The premises are not purpose built but a ramp has been fitted to enable ease of access for patients with mobility difficulties and a hearing loop has recently been ordered. There is a lift to provide access to consulting rooms on the first floor.

If no appointments are available, patients can be referred to the Lambeth GP access hub (which provides additional GP and nurse appointment at four specific GP practices spread across the borough). The closest of these to this practice is just over half a mile away at the West Norwood Leisure Centre.

The practice is registered with the Care Quality Commission to carry on the regulated activities of maternity and midwifery services, treatment of disease, disorder or injury, family planning, surgical procedures, and diagnostic and screening procedures.

The practice has a higher percentage than the national average of people with a long standing health condition (59% compared to a national average of 54%). The average male and female life expectancy for the CCG area and the practice is in line with the national average for both males and females.

The population in this CCG area is predominantly white British. The second highest ethnic group is black or black British. The practice sits in an area which rates within the fourth most deprived decile in the country, with a value of 29.1 compared to the CCG average of 28.9 and England average of 21.8 (the lower the number the less deprived the area).

Detailed findings

The patient population is characterised by an above England average proportion of patients, male and female, between the ages of 25 and 54; and a below England average proportion of patients, male and female, over the age of 60.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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. The practice was previously inspected in May 2013, at which time it was found to be compliant.

How we carried out this inspection

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 23 August 2016. During our visit we:

- Spoke with a range of staff, including GPs, the practice manager, a practice nurse and administrative/reception staff; and spoke with patients who used the service.

- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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 were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and record this in an incident book.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out an analysis of the significant events. We were sent their log which showed there had been two significant events in 2016. The log contained details of the action taken and the learning that came out of the event. For example, a patient became unwell in the waiting room and had required emergency medicines. The first member of staff who went to get them could not locate the medicines needed. They were subsequently found but what could have been a significant delay had occurred. This event was reviewed and as a result staff took action to reduce the amount of stock in the emergency medicines cupboard so that items could be easily seen; and all staff were made aware of the location of emergency medicines. We noted that a recent significant event had not yet been recorded in the log, although staff were able to give us full details of the event and the action taken. The practice send us a copy of the log after the inspection which showed the event had been added.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, staff were able to discuss a recent safety alert regarding one type of blood glucose monitoring machines. As a result checks had been made of all eligible patients to ensure that none used the machine in question, or if they did, that it was replaced. We were also given a copy of a recent alert from the Medicines and Healthcare products Regulatory Agency (MHRA) relating to the recall of a batch of medicines.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. We noted the safeguarding children policy did not contain details of who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The GP and practice manager were trained to child protection or child safeguarding level 3. The practice nurses to level 2, and all other staff to level 1. All clinical staff had also undergone adult safeguarding training.
- A notice in the waiting room and in consulting rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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). An entry was made into a patient's notes if a chaperone was provided.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. An infection control audit had been undertaken in 2015 by the local Clinical Commissioning Group. It identified several areas for improvement. Whilst we were told the practice was addressing these, there was no written action plan or log of action taken and improvement made as a result.
- Following discussion at the inspection the practice established a separate cleaning rota for the minor

Are services safe?

surgery operating room, and we were sent a copy of an infection control audit carried out following the inspection. This audit had not found any issues of concern.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice's prescribing indicators were in line with CCG and national figures. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse).
- Most staff had been recruited more than three years ago, which was before GP services were regulated by CQC. We reviewed one personnel file of a more recent recruit and found appropriate recruitment checks had been undertaken or requested prior to employment. For example, proof of identification, references and employment history. We saw two references had been requested although only one had been obtained. We were told that gaps in employment history had been explored; however, this information was not within the staff file. We were also told that the member of staff had confirmed their identity through their birth certificate, although this had not been recorded.
- The practice told us they used locum GPs on a weekly basis and tried where possible to use the same locums to provide a level of continuity and familiarity with systems. They had a locum induction pack in place.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and the practice manager led on health and safety. The practice carried out regular fire alarm checks. We were told that regular fire drills were carried out however these were not recorded. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice manager told us an external company had recently carried out a fire risk assessment, health and safety risk assessment, legionella check (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) and a check with regard to the accessibility of the building for patients with a disability. They were waiting for the report, but we were told that urgent issues had been dealt with. The urgent issues related to fire safety and the practice had installed new signage as a result. We noted that a gas safety check has been carried out earlier in the year. This had resulted in a safety warning notice relating to support for a vent, which the practice had not yet addressed.
- We noted damage to a wall in one of the consulting rooms, and a cracked window pane. A lift was installed in the premises; however, the practice could not provide evidence of recent maintenance. Following the inspection we were sent a copy of the most recent lift maintenance visit, which took place in July 2016.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Non-clinical staff had received training for a number of different roles so that they could cover for each other. They also made good use of a handover book.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff had undergone basic life support training in June 2016, and there were emergency medicines available in the treatment room.

Monitoring risks to patients

Risks to patients were assessed and generally well managed.

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. They also accessed relevant clinical journals, websites and attended peer group meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available, compared to the CCG and England average of 95%. The practice had a higher exception rate for the percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months than both the CCG and England (11.11% compared to 5.81% and 8.3% respectively). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). It also had a higher exception rate for the percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years (7.21% compared to 4.59% and 6.3% respectively).

The exception rates for atrial fibrillation and peripheral arterial disease were also higher than CCG and England averages (practice - 20%; CCG - 12.7%; England 11.0% and, practice -13.6%; CCG - 4.9%; England 5.8% respectively). The practice's overall clinical exception rate, however, was 7%, which was comparable to the CCG average of 7.5% and national average of 9%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to or above the national average. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2014 to 31/03/2015) was 75% compared to the CCG average of 73% and England average of 78%. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less (01/04/2014 to 31/03/2015) was 86% compared to the CCG and England average of 80%. The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (01/04/2014 to 31/03/2015) was 94% compared to the CCG average of 87% and England average of 88%.
- Performance for mental health related indicators was better compared to the national average. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 97% compared to the CCG average of 85% and England average of 89%. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months (01/04/2014 to 31/03/2015) was 97% compared to the CCG average of 87% and England average of 90%.

There was evidence of quality improvement including clinical audit.

- There had been three clinical audits completed in the last two years, one of these was a completed audit where the improvements made were implemented and monitored. We also saw the practice had a number of action plans arising from initial audits to address areas where the need for improvement had been identified. These included a hypertension plan aimed at improving patients' blood pressure control and an asthma quality improvement plan.
- Findings were used by the practice to improve services. For example, recent action taken as a result of the diabetes audit included additional information leaflets being ordered for patients and educational resources being accessed through the virtual clinic and distributed to the practice nurses.

Are services effective?

(for example, treatment is effective)

Information about patients' outcomes was used to make improvements such as offering all asthma, as well as COPD (chronic obstructive airways disease) patients a spirometry test; providing a spacer to all patients using an inhaler and to provide a CO2 check to all patients with asthma, COPD and to those patients who were smokers.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example staff had attended a variety of training courses including moving and handling, equality and diversity, customer care, accident and incident reporting, risk management, patient confidentiality, consent and mental health.
- Staff administering vaccines had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. The practice nurses attended annual immunisation update training, and update training for flu vaccinations.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Clinical staff received annual appraisals from the GP. Non-clinical staff received them from the practice manager. Staff confirmed to us that these were taking place. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, clinical supervision and support for revalidating GPs.
- Staff received training that included: safeguarding, chaperoning, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. We saw examples of care plans which were well completed. Where unplanned hospital admissions had occurred we saw the GP reviewed the discharge information and where appropriate arranged a review with the patient.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We saw the practice took part in virtual clinics, with, for example consultant geriatricians.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. We saw minutes of meetings with the local hospice, the district nurse and the health visitor.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. The practice had consent forms for specific areas, including family planning and minor surgery.

- Staff had a broad understanding of the relevant consent and decision-making requirements of legislation and guidance, but had not undergone training in the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. The GP was familiar with Gillick competencies and Fraser guidelines (Gillick competencies and Fraser guidelines are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and patients with mental ill health or a learning disability. Registers were maintained for these patients, and they were invited for annual health reviews.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 79.7% and the national average of 81.9%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast

cancer screening, and its screening rates were comparable to the CCG and national averages. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Child immunisation rates were comparable to or above the CCG averages in all but two areas. The percentage of children aged 24 months who received the Infant Men C immunisation was 67% (CCG average 81%) and those aged 5 years who received the Dtap.IPV Booster was 74% (CCG average 83%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 87 patient Care Quality Commission comment cards we received were positive to a greater or lesser degree about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They felt the group was able to actively contribute and that they were listened to. The PPG had 26 members, but they felt this needed to be increased. There was no information about the PPG in the waiting room, and the members told us they had requested a PPG specific notice board so that they could display information about the group and encourage new members to join. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Practice results from the national GP patient survey for its satisfaction scores on consultations with GPs and nurses were comparable to the CCG and England averages. For example:

- 77% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 79% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.

- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.
- 91% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86.5% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 87.5% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- 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 caring?

- Information leaflets were available for a range of topics including sexual health, cancer screening and psychological therapies. None were available in languages other than English; however, the practice manager told us that should a patient request information in another language they would provide it.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations, including bereavement support. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 89 patients as carers (3% of the practice list). Carers were offered annual flu jabs; were signposted to the various avenues of support available to them, and where appropriate the practice assisted in finding respite care.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice offered a weekly minor surgery clinic, and accepted referrals from other practices.

- The practice offered late appointments on a Thursday evening until 7.50pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities and translation services available. A hearing loop had recently been ordered. Other reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services. For example a ramp had been fitted to the rear of the property so that wheelchair users could access the surgery.
- The practice had established effective partnerships with other GP colleagues and patients as it developed its minor surgery service. In the year April 2015 - April 2016 the GP had carried out 163 procedures. In the first quarter of the year April 2016 – April 2017 it had already carried out 101. The practice commented that this facility had empowered patient choice, had prevented a number of hospital admissions and was cost effective. The increasing number of procedures reflected this.
- The practice did not have a permanent female GP. This was raised as an issue by the patient participation group. The practice told us that when they used locum GPs they would try to ensure they were female.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 9am to 12pm every morning and 3pm to 6pm daily. Extended hours appointments were offered on Thursdays up to 7.50pm. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was to the same or above local and national averages.

- 78% of patients were satisfied with the practice's opening hours the same as the national average.
- 92% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People told us on the day of the inspection that they were usually able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

If patients called for an urgent appointment this request would be passed to the GP who would call the patient back. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective 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. We noted however that the policy had not been made practice specific – for example the name of the staff member leading on complaints had not been inserted.
- 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 – the complaints leaflet was available in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

We looked at three complaints received in 2015 (no complaints had been logged for 2016) and found these were satisfactorily handled and dealt with in a timely way. Patients were given apologies where this was appropriate. Lessons were learnt from individual concerns and complaints and action was taken to as a result to improve

the quality of care. For example, a complaint had been made about reception staff, as the patient had felt they were not listening because they were trying to deal with two patients at once. The practice had reviewed staffing levels and had recruited an additional receptionist.

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 had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The practice had defined objectives for the forthcoming 12 months. The priority was to recruit a female GP.
- Practice specific policies were implemented and were available to all staff electronically.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements, although only a minority of audits had been completed with a re-audit.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the GP demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the GP was approachable and always took the time to listen to all members of staff.

The GP was aware of the requirements of the duty of candour but other staff were not familiar with the terminology. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Nevertheless staff were able to describe actions they had taken which

were in keeping with the duty of candour. The GP encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- The practice manager attended a buddy group with other practice managers in the area.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the GP and he encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively engaged patients in the delivery of the service through the patient participation group (PPG).

- The practice had gathered feedback from patients through the PPG and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, as a result of PPG suggestions the practice had improved the availability of information, including the complaints procedure. It had also extended the walk in clinic hours and improved reception staff availability at lunchtime. Patients could leave comments in a feedback box at reception, although it was not in clear view.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Are services well-led?

Good 

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

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and promoted effective collaborative work with secondary care, social care and the wider primary healthcare teams to improve outcomes for patients in the area.

The practice was proactive in meeting the needs of the young population. For example it provided long-acting reversible contraception (LARC) not only to its own patient list but for patients referred from other practices. It also accepted minor surgery referrals from other practices and continued to be successful in reducing referrals to secondary care.