Dr Goutam & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Detailed findings from this inspection

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection of Dr Goutam & Partners on 12 January 2015. This was a comprehensive inspection. We gave the practice an overall rating of 'good'. This was based on four of the five domains and six population groups we looked at achieving the same good rating. We rated the safety domain as 'requires improvement'.

Our key findings were as follows:

- Overall the practice is rated as good. However improvements are required for the safety domain because the practice had not made the required employment checks for new employees and had not ensured an employee had continued registration to practice as a nurse.
- Patients rated the practice and staff highly and felt welcomed and well cared for.
- Arrangements were in place to maintain the appropriate standards of cleanliness. The practice was clean
- Systems were in place to identify and respond to concerns about the safeguarding of adults and children. All staff demonstrated a good awareness of the processes.
- Care provided was evidence based and in line with local and national guidance.
- Patients reported the 'usual doctor' system allowed them to see the same doctor every time which ensured continuity of care.

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

Importantly, the provider must:

- Ensure the recruitment policy complies with current legislation and directives
- Carry out the required pre-employment checks on relevant current staff where this check was incomplete

Summary of findings

- Install systems to carry out periodic checks so nursing staff continue to meet the professional standards which are a condition of their ability to practise

In addition the provider should:

- Ensure written guidance is available to clinical staff on medicine management
- Ensure validated directions are available to staff that administer vaccines
- Introduce a system so blank prescription forms are tracked through the practice and kept securely
- Ensure furniture with torn vinyl or other covering is either repaired or replaced
- Commission a legionella risk assessment by a competent person and address any identified risks to the water system
- Identify areas where liquid nitrogen and oxygen are stored and mark them with 'hazardous substance' notices
- Commission a risk assessment of the premises and the practice environment and address any identified potential or actual risks
- Make all possible efforts to reconvene the Patient Participation Group (PPG)
- Consider options to help patients in wheelchairs communicate with the receptionist without being overheard
- Develop suitable written information to patients on how to complain
- Develop a business plan
- Ensure policies and procedures reflect and comply with the requirements of legislation and directives
- Develop a system to confirm all staff have been appraised

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 are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Although risks to patients who used services were assessed, the systems and processes to address these risks such as new employee pre employment checks and continued registration checks with the professional regulator for nurses were not implemented well enough to ensure patients were kept safe.	**Requires improvement**
Are services effective? The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.	**Good**
Are services caring? The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.	**Good**
Are services responsive to people's needs? The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. 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.	**Good**

Summary of findings

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 with staff and other stakeholders.	
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 and events.	**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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.	Good
People with long term conditions The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. 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 medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.	Good
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. 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. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.	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	Good

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.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice 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 about how to access various support groups and voluntary organisations such as MIND. 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.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our inspection. They told us that GPs and practice staff treated them with compassion, listened to them and explained treatment options and procedures in a way they understood. Many patients commented that the 'usual GP allocation' allowed them to see the same GP when they attended, which gave them a sense of continuity of care.

We received four comment cards. Comments left for us were very positive and noted the 'excellent' service provided by the practice and noted the 'considerate' care provided by the GPs.

Information from the National GP Patient Survey showed that the practice could improve by involving the patients more in their care and treatment. What patients told us and the comments left for us in comment cards did not corroborate the information from the National GP Patient Survey.

Areas for improvement

Action the service MUST take to improve

- Ensure the recruitment policy complies with current legislation and directives
- Carry out the required pre-employment checks on relevant current staff where this check was incomplete
- Install systems to carry out periodic checks so nursing staff continue to meet the professional standards which are a condition of their ability to practise

Action the service SHOULD take to improve

- Ensure written guidance is available to clinical staff on medicine management
- Ensure validated directions are available to staff that administer vaccines
- Introduce a system so blank prescription forms are tracked through the practice and kept securely
- Ensure furniture with torn vinyl or other covering is either repaired or replaced
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Dr Goutam & Partners

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 and a practice manager acting as specialist advisers.

Background to Dr Goutam & Partners

Dr Goutam & Partners provide a range of personal medical services for people of Houghton Regis in Bedfordshire and serve a registered population of approximately 10500 patients. The practice population is predominantly white British but the practice also serves patients from the ethnic minority groups mostly of eastern European and Asian backgrounds.

Clinical staff at this practice include five GP partners, one practice nurse, and two healthcare assistants. Management, administration and reception staff support the practice. Community nurses, health visitors and a midwife from the local NHS trust also provide a service at this practice. A mix of male and female clinical staff is available.

Students from two London medical schools train at the Practice.

Out of hours care when the surgery was closed was through the NHS 111 service.

Why we carried out this inspection

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

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

Detailed findings

- 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)

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 12 January 2015.

During our visit we spoke with a range of staff including GPs, reception staff, nurses, the practice manager and other practice staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. 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. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were discussed during the weekly practice meetings where appropriate actions and learning points were agreed and we saw records of these meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, to the contraceptive coil fitting procedure so any pre-existing infections can be diagnosed during this procedure and treated. This helped the practice to provide an improved service. GPs, nursing staff, receptionists, and other practice staff we spoke with knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety and medicines alerts were reviewed by the practice manager on receipt and shared with staff appropriately to ensure they were noted and acted upon.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children and adults.

There were procedures for escalating concerns to the relevant protection agencies. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Where training updates were due we saw that these had been booked. There was a system on the practice's electronic records that alerted the GPs and practice nurses when a safeguarding issue or safeguarding plan had been identified and developed for individual patients.

Liaison with the health visitor was evident and the health visitor told us that the GPs communicated with them well in providing care for children at risk. They told us that information sharing was timely with documentation of safeguarding concerns available to them and other healthcare professionals through the patient's electronic records.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary safeguarding training to enable them to fulfil this role. Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

We saw that the practice team had regular monthly meetings which were attended as appropriate by the health visitor, school nurse and the social worker. The midwife did not attend practice meetings as they saw their patients at a nearby surgery but communicated regularly with the GPs. On-going safeguarding issues were usually discussed at these meetings with plans agreed for keeping patients safe. The safeguarding lead or the patient's usual GP contributed to case conferences and reviews and where appropriate and sent written reports when unable to attend.

The GPs reviewed children and young people that had attended A&E and liaised with the health visitor and school nurse for any follow up actions that was needed. The practice followed up children who failed to childhood immunisations and current data showed that the practice had performed better than similar practices in the local area for childhood immunisation.

There was a system on the practice's electronic records that alerted the GPs and clinical staff to vulnerable patients. The practice operated a 'usual doctor' system whereby patents were seen by the same doctor which ensured continuity of care. Where appropriate the community matron was also aware. This was particularly relevant to vulnerable patients that lived in nearby care and nursing homes so their care and treatment were regularly reviewed.

Requires improvement

Are services safe?

A chaperone service was offered and notices were visible on noticeboards in the waiting room and inside consultation rooms. There was no chaperone training for staff, but the practice manager told us that it was practice policy to use clinical staff only to act as chaperone.

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 community matron we spoke with described the process for checking so medicines were kept at the required temperatures, and the action to take in the event of a potential failure. We however did not see any written instructions to clinical staff on medicine management.

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.

The practice nurse administered vaccines. We however did not see any guidance to staff such as the directions that had been produced in line with legal requirements and national guidance on the use of and administration of vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice did not have a system for recording/tracking serial numbers of blank prescription forms in accordance with national guidance so these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. An external contractor cleaned the practice. We saw there were cleaning schedules in place and cleaning records were kept. The practice manager told us that they carried out periodic checks on the cleanliness of the practice. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

A GP assisted by the practice nurse led on infection control. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that audits on infection control and prevention had been carried out. For example we saw that improvements to identify and minimise infections had been identified for action following an audit of contraceptive coil insertions.

An infection control policy was available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury, The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. We saw sharps containers that were labelled correctly and not overfilled.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Clinical staff maintained infection control measures in treatment and consultation rooms after each patient was seen and we saw that there were adequate supplies of personal protection equipment such as gloves and aprons. The treatment and consultation rooms we inspected appeared clean and tidy. Although we noted the covering on the phlebotomy chair and a couch in separate consultation rooms had a tear which posed an infection risk. Curtains in consultation rooms and in the treatment room were of the disposable type and had been replaced periodically.

The practice manager told us that they had not undertaken a review of the risks posed by legionella (a germ found in the environment which can contaminate water systems in buildings) to their water system. The practice manager also told us that any risk posed was minimal as the building had no water storage tanks and that the air conditioning system was self-contained.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of

Are services safe?

calibration of relevant equipment; for example the ECG machine which is used to monitor the heart and the spirometer that is used to measure breathing had been calibrated in March 2014.

Staffing and recruitment

We looked at the files of three staff that had been recruited in the past six months. This showed us that appropriate recruitment checks had not been undertaken prior to their employment. There was no evidence of reference checks on two of the three staff. One of the staff files belonged to a person that undertook health care duties. We did not see evidence of criminal records checks for this person through the Disclosure and Barring Service (DBS). There was no evidence of a risk assessment on the need for a criminal records check for the other two staff. We reviewed the practice's recruitment policy and found that it was not explicit on the employment checks required by schedule 3 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, such as obtaining proof of identification, references, checks on qualifications, and registration checks with the appropriate professional body. We asked to see the registration status of a nurse and the practice could not confirm their status. This was because there was no system to carry out periodic checks so nursing staff continued to meet the professional standards which are a condition of their ability to practise. A check on their professional body website showed that this person was not currently registered as a nurse. The practice manager told us that they would take immediate action to remove this nurse as well as the other person who undertook health care duties from providing direct patient care.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staffing numbers were mainly based on historic data. All staff usually worked practice hours and covered each other for holidays study days and other absences through a buddy system.

Staff told us there were usually enough clinical staff to maintain the smooth running of the practice but thought support staff hours should be increased to keep up with increased workload. For example keeping staff records updated.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors. These included regular checks of the building, the environment, medicines management, staffing and dealing with emergencies and equipment. There was a health and safety policy which was available within the staff handbook. We saw that clinical risks were discussed at GP partners' meetings and within team meetings.

Care and treatment was provided in an environment that was well maintained. Appropriate arrangements were in place for maintenance of the building and equipment. Fire alarms and extinguishers were available throughout the building. The fire exits were well signposted and free from hazards to prevent escape in an emergency. We saw evidence of a recent fire risk assessment. Emergency lighting and fire extinguishers had also been recently tested. We however did not see evidence of a recent full risk assessment of the premises and the practice environment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records which showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen. Staff knew the location of the equipment and records showed it was checked regularly. Hazardous substance warning notices were not displayed on the door of the room where the liquid nitrogen and oxygen were stored.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check the emergency medicines were within their expiry date and suitable for use. The emergency medicines we checked were clearly labelled, 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 power failure, loss of heating, and loss of the telephone or computer system. All staff had access to the plan. Key contact names and telephone numbers were recorded in it.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs were familiar with and followed National Institute for Health and Care Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) guidance around treatment and prescribing. The practice also received regular updates from the Clinical Commissioning Group (CCG) and from Luton and Dunstable hospital. SystmOne the clinical computer system used by the practice has links to NHS summaries and guidelines and referral pathways. Relevant alerts were discussed during weekly practice meetings with appropriate actions agreed. We saw records of such discussions. The GPs told us they lead in specialist clinical areas such as management of chronic conditions like diabetes, heart disease and women's health and the practice nurse supported this work.

A GP attended the CCG locality meeting, the purpose of which was to discuss current best practice in primary care and receive updates relevant to the local area such as in health and safety, palliative care, etc. Information for such meetings were cascaded to other GP colleagues and clinical staff at the practice.

We reviewed the data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used risk stratification tools to identify patients with complex needs and we saw that these patients had multidisciplinary approach to their care and treatment. The community matron was involved in these activities and ensured such patients were monitored appropriately in the community.

All GPs we spoke with used national standards for the referral to other services. We saw records of meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Patients told us that they were extremely satisfied with the care and treatment received from GPs and nurses at the practice. Staff across the practice had key roles in monitoring and improving outcomes for patients. Information about the outcomes of patients' care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. Information from the quality and outcomes framework (QOF) which is a national performance measurement tool showed the intended outcomes were being achieved for patients. For example the percentage of women aged 25 or over and who have not attained the age of 65 that had a cervical screening test performed was better than average for this practice. Taken over a number of health outcome indicators the last available QOF data showed the practice had performed to agreed expectations or exceeded them.

QOF data was subject to on-going monitoring to ensure the needs of patients were identified and met in a timely manner. For example, to ensure that those with long term conditions, learning disabilities or mental health issues attended for regular review. The practice had systems to recall patients when their review was due and proactively follow up on any non-attendance. The data was also monitored to ensure that when patients were due for vaccinations, such as shingles, flu and child immunisations, they received them. The senior partner told us that the current QOF monitoring cycle had three more months to run and the practice was working hard to meet agreed targets as an unplanned sickness of a GP had affected QOF performance.

The practice showed us examples of clinical audits completed within the last year. These included audits on the effectiveness of antibiotic treatment of women with a urinary infection, the effectiveness of injections that are used to reduce inflammation and pain within a joint, contraception, and the prescribing of hypnotics. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit such as more effective use of antibiotics when treating urinary infections.

The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Patients were reminded of the need for a medication review by telephone text message (if consented to text) or by letter The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

New members of staff completed an induction programme that was role specific. We saw records of continued mandatory training which included fire safety, basic life support and safeguarding of adults and children. The practice also provided access to additional role specific training for clinical and non-clinical staff such as moving and handling and clinical record keeping. There were opportunities for staff to attend other internal training sessions, multi-disciplinary team and CCG hosted events. For example a Thursday afternoon during March and April 2015 had been reserved for planned learning.

All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation set. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council. All staff had an annual appraisal. During these meetings a personal development plan was put in place and training needs identified.

The practice had a process to manage poor performance both for clinical and non clinical staff.

Working with colleagues and other services

Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear mechanisms to make such referrals in a timely way and this ensured patients received appropriate co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine.

Patients had access to a mental health counselling service on site and GPs liaised with other healthcare professionals as needed. This included regular meetings with professionals such as health visitors to discuss child health and safeguarding issues, and with McMillan nurses to plan and co-ordinate the care of patients coming to the end of their life. They also liaised with the out of hours service who had access to detailed clinical information about patients with complex healthcare needs through the SystmOne clinical computer system. All patient contacts with the out of hours provider were reviewed by the GP the next working day.

A system was in place for hospital discharge letters blood test and X ray results, and attendance summaries from the out-of-hours GP 111 service to be reviewed by the responsible GP. The GPs who saw these documents and results took appropriate action as required. All staff we spoke with understood their roles and felt the system in place worked well.

Information sharing

The practice had a website with information for patients including signposting, services available and latest health and health promotion news.

There was effective communication, information sharing and decision making about a patient's care across all of the services involved both internal and external to the organisation, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

The practice had a system to communicate with other providers. We saw evidence of information sharing, for example with the out of hours service, palliative care team

Good

Are services effective?

(for example, treatment is effective)

and the Macmillan service. There were arrangements to receive hospital summaries of recently discharged patients. These were scanned and directed to the relevant GP for their review and any follow up action.

Electronic systems were also in place for making referrals, and the practice made use of the Choose and Book system for making referrals. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. A GP told us that they referred to Gillick competency when assessing young people's ability to understand or consent to treatment.

The practice administered joint injections (as a minor surgical procedure) which helped to reduce inflammation and pain within a joint, and had a process to obtain written consent before this procedure was performed. A GP told us that a record of the relevant risks, benefits and complications of the procedure would also be made in the patient's records at the same time.

The practice provided care for patients in nearby nursing homes that cared for people with dementia and provided support as needed including the use of restraint. Staff we spoke with was aware of the distinction between lawful and unlawful restraint. Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing.

Health promotion and prevention

New patients were offered a health check. This included discussions about their environment, family life, mental health, physical wellbeing as well as checks on blood pressure, smoking, diet, alcohol and drug dependency. Any health concerns found would be followed up by a GP. The practice maintained a carer register and encouraged patients declare if they were carer so the practice could arrange appropriate support.

The practice offered NHS Health Checks to all its patients aged 40-74. These checks had identified a number of patients with hypertension and those who were diabetic. Practice data showed that in the six months since April 2014, 176 patients took up the offer of the health check.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example in the preceding 12 months, 93% of patients diagnosed with dementia had been reviewed in a face to- face review.

Opportunistic chlamydia screening was offered by Brook Houghton Regis, a young people's sexual health charity, who used practice premises to provide this free service to young people under the age of 25. The also provided free and confidential sexual health services, support and advice to this age group.

The practice had identified the smoking status of 99% of patients over the age of 16 and actively offered smoking cessation advice to relevant patients. The healthcare assistant who is trained as a smoking cessation advisor offered this advice.

The practice's performance for cervical smear uptake was 94%, which was better than others in the CCG area. 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 for all immunisations was in line with the average for the CCG.

The practice offered an anticoagulant clinic on site, together with a paediatric phlebotomy (taking of blood samples from children) which helped patients obtain this service locally without the need to attend the NHS general hospital.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and all were positive about the service experienced. Patients commented that the practice offered an excellent service and staff interacted with them well and treated them with dignity and respect.

We spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They spoke highly about the practice and the care and treatment they had received. They told us that GPs nurses and practice staff were kind, friendly and helpful. They felt well looked after and staff listened and attentive to their needs.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. This survey showed that 68% reported that their GP was good at treating them with care and concern. These results which are below average for similar practices in the local CCG area do not correspond to what patients told us on the day we inspected or what they wrote on the comment cards we reviewed. The practice manager told us that they were taking action to make the patient experience better.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There was a private room available by the reception desk for use by patients whose circumstances may make them vulnerable so they could discuss their need in private without fear of stigma or prejudice.

There was a notice in the patient reception area stating the practice' zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. While 73% of the patients who responded to the national patient survey described the overall experience of their GP surgery as fairly good or very good, only 64% said the GP was good or very good at involving them in decisions about their care. Further only 70% said the GP was good or very good at treating them with care and concern. These results are below the average for similar practices in the local GGC area. The practice manager told us that they were taking action to make the patient experience better.

Patients we spoke with on the day and those who completed CQC comment cards told us they felt listened to and felt involved in decision making about the care and treatment they received. They said they felt well supported by staff. Treatment options were explained and consultations were not rushed. Patients confirmed they were always asked for their consent before any procedure or treatment was undertaken.

Staff told us that translation services were available for patients who did not have English as a first language. The GPs told us that they used an online translation service which patients and staff found very helpful.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

The practice made referrals to emotional support services such as Improving Access to Psychological Therapies (IAPT), and signposted patients to support services such as bereavement counselling and MIND the mental health charity.

Notices in the patient waiting room, and on the practice website also told people how to access a number of support groups and organisations. The practice' computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

Patients could access a male or female GP. All patients had a 'usual doctor' upon registering which enabled patients to see the same doctor and ensured continuity of care. Patients over 75 years old were sent a letter notifying them of their named GP. Routine appointments with the GPs were 10 minutes long, and the practice offered extended appointments for patients who might require them, including patients with learning disabilities, mental health conditions, multiple long-term conditions, and those over the age of 70. Patients with mental health conditions and children were also offered urgent appointments if they needed one. Home visits and telephone consultations were also offered to patients who needed them, including the housebound and older patients.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice engaged regularly with the NHS Area Team and Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example following a needs assessment the practice in partnership with a local pharmacist had introduced on site pharmacy services including home delivery of medicines and the supply of medicines in pre measured dose boxes.

We spoke with a member of the Patient Participation Group (PPG). They told us that the PPG had not been active for the past few months and that the practice was in the process of seeking renewed membership.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

Staff we spoke with had a good understanding of equality and diversity. We saw records that confirmed that all staff had attended equality and diversity training.

There was a large car park with allocated disabled parking. From the car park there was level entry to the surgery through electric automatic doors which enable easy wheelchair and pram access. All rooms used by patients were at ground level. Disabled toilets and baby change facilities were available. The waiting area and corridors were sufficiently wide to accommodate wheelchairs and pram access. The reception desk was not assessable to a patient in a wheel chair as the reception counter was set high, designed for a person who could communicate standing. The practice may wish to consider options so patients in wheelchairs could communicate with the receptionist without being overheard.

The practice had access to online translation services and four GP were conversant in Asian languages.

Access to the service

Appointments were available from 8.00 am to 6.30 pm on weekdays. Extended opening hours were available on Wednesdays till 8 pm. On alternate Saturdays the practice was open for pre-bookable appointments only from 8 am till 10 am. Patients could book appointments in person, on the telephone or on line through the practice website. The practice manager told us that about 10% of the practice population currently used the online booking facility.

Comprehensive information was available to patients about appointments on the practice website including the days specific doctors were available for consultation. Information provided included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, a recorded message gave the telephone number they should ring for the out-of-hours service.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care homes on a specific day each week, by a named GP and to other patients who needed one.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

There was a notice in the reception area informing patients how to make a complaint. 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 however did not see a dedicated leaflet that gave patients information on how to complain nor was such information available on the practice website.

A complaints log was kept and we reviewed the complaints received in the last six months and found that these had been investigated and responded to in a timely manner. Staff told us that complaints received were discussed during practice meetings so they were able to learn and contribute to determining any improvements that may be required. We reviewed the minutes from practice meetings which showed evidence of discussion shared learning. Staff we spoke with were aware of the system in place to deal with complaints.

We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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 senior partner told us that their vision was to provide good and appropriate service to their population which promoted good outcomes for their patients. The practice staff had been very proactive to realise this vision, and achievements included the provision of on-site pharmacy, an extension to their building to provide an additional consultation room, and meeting or exceeding the QOF targets. The practice was also actively seeking to make available locally services that are currently available only in larger healthcare facilities. So far the practice had introduced an anticoagulant clinic and a paediatric phlebotomy (taking of blood samples from children) service which was more convenient to the patient without the need to attend the NHS general hospital.

We found that staff knew and understood the practice vision and values, and what their responsibilities were in relation to these. We however did not see a written strategy or a business plan.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in the practice manager's office. We randomly looked at five of these documents and found that these had recent review date. The recruitment policy, though it was designated as current did not reflect and comply with the requirements of legislation and directives such as the need for appropriate employment and registration checks, and had resulted in these checks being missed for some employees.

A clear governance structure was evident. The management team consisted of the five GP partners and the practice manager, and they met on a regular basis to discuss how the practice was run. They also had designated roles and attended meetings with the Clinical Commissioning Group (CCG), local networking group, and local practice managers as appropriate.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Clinical audits were regularly undertaken by the practice GPs. We were shown records of completed audits the practice had undertaken during the past twelve months. These included audits on the effectiveness of antibiotic treatment of women with a urinary infection and another that concerned contraception. The practice was able to demonstrate the changes resulting since the initial audit such as more effective use of antibiotics when treating urinary infections and cost effective use of contraceptives.

The practice had arrangements for identifying, recording and managing clinical risks. Clinical risks were discussed at GP partners' meetings and within team meetings. However there was no evidence of a recent full risk assessment of premises and the practice environment.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a GP lead for infection control and another GP was the lead for safeguarding. We spoke with four 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.

A hard copy of the staff handbook was available to all staff, and included sections such as the annual appraisal process. A whistleblowing policy was in place, and staff we spoke with knew how to access this if required.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

Seeking and acting on feedback from patients, public and staff

The practice had in November 2013 gathered feedback from patients through an in-house practice survey supported by the patient participation group (PPG). As a result of this survey, which showed patients were dissatisfied with the length of time it took to receive an appointment, and the length of time it took to access the practice over the phone the practice had introduced online appointment system. The practice manager told us that this system was still evolving with about 10% of the practice population using the online service.

Are services well-led?

Good

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

The practice patient participation group (PPG) was currently inactive and the practice manager told us that they were seeking to reconvene the PPG soon.

We saw minutes from practice meetings which were held monthly. Staff told us that there was an open culture within the practice and the practice meetings provided an opportunity to provide feedback. Staff also commented that the management team were approachable, and they could speak with them in private if they could not raise their concerns during practice meetings

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that they had appraisals, which included a personal development plan, and took place annually. GPs also received appraisal through the revalidation process, and records were kept by the GPs themselves. However the practice had no records of the appraisals.

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. We saw evidence of discussion during practice and team meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person: 1. Did not operate effective recruitment procedures and had not carried out the pre employment checks specified in Schedule 3 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. These checks include obtaining proof of identification, checks of references, qualifications, professional registration and a criminal records check through the Disclosure and Barring Service (DBS). This was in breach of Regulation 21 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (2) (a) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 2. Had not ensured that a person employed for the purposes of carrying on a regulated activity was registered with the relevant professional body where such registration was required for this person to work as a registered nurse. This was in breach of Regulation 21 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 3. Failed to take appropriate steps in relation to a person who is no longer fit to work for the purposes of carrying on a regulated activity by not informing Nursing and Midwifery Council (the body responsible for regulation of the health care profession in question).

Requirement notices

This was in breach of Regulation 21 (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.