

Dr Kandiah Pathmanathan

Quality Report

Covent Garden Medical Centre
47 Shorts Gardens
London WC2H 9AA
Tel: 0207 379 7209

Website: www.coventgardenmedicalcentre.nhs.uk

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on the 5 March 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing caring and responsive services. It required improvement for providing safe, effective and well-led services. Because the practice is rated as requires improvement in the key questions of safe, effective and well-led, these ratings apply to everyone using the practice, including the six population groups - older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Staff were not sufficiently trained to make full use of the practice's clinical computer system to monitor, fully assess and manage patient outcomes.
- Data showed patient outcomes were below average for the locality.
- Although some audits had been carried out, there was limited evidence that audits were driving improvement in performance to improve patient outcomes.
- 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 in a format patients could understand.
- Urgent appointments were usually available on the day they were requested.

Summary of findings

- The practice had a number of policies and procedures to govern activity, but a number of these were in need of review.
- There was no evidence to confirm that staff received regular appraisals.

The areas where the provider must make improvements are:

- Continue to access appropriate training and support relating to the new clinical computer system so that staff may make full and effective use of the system to ensure that patient outcomes are assessed and appropriately managed and that risks to patients' health and welfare are mitigated.

In addition the provider should:

- Continue carrying out regular audits and ensure that audit cycles are completed to drive improvement in performance to improve patient outcomes.
- Consider and take appropriate steps to meet the needs of female patients who may be reluctant to see the male GP and male locum doctors at the practice.
- Review and update as appropriate the practice's governance policies and procedures.
- Record staff appraisals and have appropriate evidence available for inspection.

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.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Staff were not sufficiently trained to make full use of the practice's clinical computer system to monitor and fully assess risks to patients' health.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services and improvements must be made.

Data showed patient outcomes were at or below average for the locality. Rates for health checks of patients on the diabetes register and mental health register were low, as was the number of patients with learning disabilities receiving annual follow ups.

Although a system of clinical audits had been introduced, no audit cycles had been completed to drive improvement in performance and to improve patient outcomes.

Staff had generally received training appropriate to their roles. However, there was need for continuing appropriate training to be provided to make full and effective use of the practice's clinical computer system, to ensure that basic care and treatment needs are met.

Staff worked with multidisciplinary teams.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and generally accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand.

Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. Patients had raised concerns regarding the lack of a female GP at the practice and this had an impact on outcomes, with some female patients being referred to other services to meet their health care needs.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led.

It had a 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, but some of these were overdue a review. The practice had begun to proactively seek feedback from patients and had an active patient participation group (PPG).

All staff had received inductions and attended staff meetings. Staff told us that they received regular appraisals, but there was no evidence to confirm this.

Requires improvement



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 requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group, 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.

Requires improvement



People with long term conditions

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

Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.

However, not all patients had a structured annual review to check that their health and care needs were being met.

Requires improvement



Families, children and young people

The practice is rated as requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group, 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, with the practice maintaining a child protection register. Immunisation rates for the standard childhood immunisations were lower than CCG and national averages, but there were few eligible children registered with the practice.

Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. Appointments were available outside of school hours. The premises were suitable for families, children and young people.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The practice is rated as requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group, working-age people (including those recently retired and students).

The 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.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement 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. However, the practice had carried out annual health checks for only three of the five patients on the learning disabilities register.

The practice 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.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

Only 16 people experiencing poor mental health had received an annual physical health check, being 41% of those eligible. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health. 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 including MIND and SANE.

Requires improvement



Summary of findings

Staff had received training on how to care for people with mental health needs.	
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Summary of findings

What people who use the service say

We spoke with 5 patients on the day of the inspection and reviewed 18 completed Care Quality Commission comments cards. Feedback from patients was generally very positive about the staff and the service.

Patients told us that staff were efficient, caring and understanding and that they were treated with dignity and respect. 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 they wished to receive. They were satisfied with the appointments system and said it was easy to use.

One person said the current lack of a nurse at the practice had an impact on their care. (We were told by the practice after the inspection that a nurse had been appointed.) Two female patients told us the lack of a female doctor at the practice was a concern for them.

We also looked at reviews left by patients on the NHS Choices website and 15 NHS Friends and Family cards completed by patients. These were consistently complimentary about the service.

Areas for improvement

Action the service **MUST** take to improve

- Continue to access appropriate training and support relating to the new clinical computer system so that staff may make full and effective use of the system to ensure that patient outcomes are assessed and appropriately managed and that risks to patients' health and welfare are mitigated.

Action the service **SHOULD** take to improve

- Continue carrying out regular audits and ensure that audit cycles are completed to drive improvement in performance to improve patient outcomes.

- Consider and take appropriate steps to meet the needs of female patients who may be reluctant to see the male GP and male locum doctors at the practice.
- Review and update as appropriate the practice's governance policies and procedures.
- Record staff appraisals and have appropriate evidence available for inspection.

Dr Kandiah Pathmanathan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. It included a GP, a practice nurse, a practice manager and an expert-by-experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. They were all granted the same authority to enter the practice as the Care Quality Commission (CQC) inspectors.

Background to Dr Kandiah Pathmanathan

The practice operates from the Covent Garden Medical Centre, 47 Shorts Gardens, London WC2H 9AA.

The practice provides NHS primary medical services through a General Medical Services (GMS) contract to approximately 2,800 patients. The practice is part of the NHS Central London (Westminster) Clinical Commissioning Group (CCG) which is made up of 37 general practices. It is registered with the CQC to provide the regulated activities Diagnostic and screening procedures, Family planning, Maternity and midwifery services, and the Treatment of disease, disorder or injury.

The patient profile for the practice indicates a population of more working age people than the national average, with a particularly high proportion of younger adults. Many of the patients registered with the practice are adults working or studying in the area. There is a lower proportion of families with children and older people in the area compared with the national average.

Dr Pathmanathan is a sole practitioner, having operated the practice for over twenty years, originally in partnership with other GPs. Many of the patients have been registered since the practice started. Dr Pathmanathan has worked on his own for the last seven years. The practice employed a female health care assistant, but there was no nurse working there at the time of the inspection. The practice was actively recruiting and we were later informed that a female nurse had been appointed in April. There was a practice manager and an administrative team of five. The practice manager had recently been appointed, but had worked at the practice for a number of years in an administrative role. Locum GPs were engaged when required to cover for the doctor's occasional absence.

The practice opening hours were 8.00am to 6.30pm Monday, Tuesday, Thursday and Friday and 8.00am to 8.00pm on Wednesday. Lunch hours were 1.00pm to 2.00pm. The practice did not open after lunch on Wednesday until 5.00pm, to allow for training and staff meetings. Consulting hours were 8.00am to 11.30am Monday to Friday; 3.00pm to 6.30pm on Monday, Tuesday and Friday; 5.30pm to 8.00pm on Wednesday and 5.00pm to 6.30 pm on Thursday.

The practice had opted out of providing out-of-hours (OOH) services and referred patients to the local OOH provider when closed. There was also information provided to patients regarding a nearby walk in centre, a service available to all patients which opened seven days a week, and regarding the NHS 111 service.

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.

Detailed findings

We had last inspected the practice in July 2014. Following that inspection we took action against the practice as we judged it did not protect patients and others, against the risk, of inappropriate or unsafe care by means of the effective operation of systems designed to enable the practice to assess and monitor the quality of the services. This was the requirement of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Specifically, the practice had not carried out any clinical audits or other activity to monitor the quality of the service, it had not carried out patient surveys since November 2011, it did not monitor patients' concerns and comments recorded on the NHS choices website and it had not established a Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

We carried out this inspection to check on the actions the practice had taken to meet the requirement of the regulation, to check whether the provider is meeting the other 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.

How we carried out this inspection

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

- Is it safe?

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on the 5 March 2015. During our visit we spoke with a range of staff, including the GP, health care assistant and administrators. We spoke with five patients who used the service and a representative of the patient participation group.

We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 18 comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice had some systems, processes and practices to keep people safe, but these were not always reliable. The practice had changed to a new computer system five months previously. Staff told us they were encountering problems in using the new system. They were having difficulty using all the facilities, for instance flagging patients who might be at risk, to make sure staff were aware of any relevant issues when patients attended appointments. The practice was mostly relying on a manual inspection of records to identify patients at risk. Training on the new computer system had been given to staff and support was being provided by the CCG. However, staff recognised that more training on the system was required for it to be put to effective use. The practice told us after the inspection that more training sessions had taken place and support from the CCG was on-going.

The practice used a range of other 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 12 months which showed the practice had managed these consistently over time.

Learning and improvement from safety incidents

There was system for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of seven significant events that had occurred during the last 12 months years and saw this system was followed appropriately. Significant events were discussed at practice meetings to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue with the doctor or practice manager or for consideration at meetings and they felt encouraged to do so.

Staff had access to incident forms and would pass completed forms to the practice manager, who showed us the system used to manage and monitor incidents. Any learning from incidents was recorded and discussed at staff meetings. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at meetings if appropriate to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Most staff were able to tell us how to recognise signs of abuse in older people, vulnerable adults and children. Staff we spoke with were aware who to speak with in the practice if they had a safeguarding concern. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were available in the reception area. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. The GP attended quarterly CCG safeguarding meetings. At the time of the inspection there were no children on the child protection register.

The practice had a chaperone policy, although we noted it was dated November 2012 and was therefore in need of review. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice manager and the health care assistant had been trained to be a chaperone. They understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination and had received Disclosure and Barring Service (DBS) checks. (DBS checks

Are services safe?

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).

The health care assistant told us they would telephone the parents or carers of children who failed to turn up for immunisations and ask for confirmation that they did not wish to have the children immunised.

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. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. The fridges were clean, appropriately stocked and well-labelled. We saw that supplies of immunisations were signed for upon receipt and the batch number recorded.

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

All prescriptions were reviewed and signed by the GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which were monitored by the doctor in accordance with national guidance. Appropriate action was taken based on the results. We checked a number of patient records which confirmed that the procedure was being followed.

The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to in accordance with a PSD from the prescriber.

We noted that the practice's repeat prescribing procedure document was undated, with no indication of the last review, and the procedure document regarding use of the vaccine fridge was dated November 2012, and therefore was overdue a review.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning was done by a contractor in accordance with cleaning schedules, which had been revised in November 2014. We saw that records of frequent daily checks were maintained and that a communications book was used to raise issues with the cleaning contractor. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy, which was dated June 2014, and supporting procedures were 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 and staff knew the procedure to follow in the event of an injury.

The practice manager was the infection control lead and had undertaken further training to enable them to provide advice on the practice infection control policy. Records showed staff had completed online infection prevention and control training. We saw evidence that the practice had carried out infection control and hand hygiene audits during the last twelve months and that any improvements identified for action were completed on time. Staff told us the results had been discussed at practice meetings, but we did not see evidence of this.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The couch roll was changed after each patient consultation. All instruments were single-use and were disposed of appropriately. There was a contract in place with a licenced contractor for the removal of clinical waste.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can

Are services safe?

contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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 which was August 2014. A schedule of testing was in place. There was evidence of testing and calibration of relevant equipment, for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer, being carried out in August 2014.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to be followed when recruiting clinical and non-clinical staff. Recruitment of non-clinical staff was undertaken by an agency on behalf of the practice, in accordance with the practice policy. We saw evidence of appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. Disclosure and Barring Service checks were carried out by the practice manager and these had been done. (These 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).

Staff told us about the arrangements for planning and monitoring the number of staff needed to meet patients' needs. Locum doctors were used occasionally to cover the GP's absence. We saw there was a rota system in place for non-clinical staff to ensure there were always enough on duty. We saw from employment contracts that staff might be required to cover each other's absence.

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 to the practice. These included regular checks of the building, the environment, medicines management,

staffing, dealing with emergencies and equipment. We saw that daily safety check lists were completed. The practice had a health and safety policy, although we noted it had not been updated since 2008. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, the premises landlord in the event of a heating failure. The plan was last reviewed in 2014.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Staff were up to date with fire training. We saw that there was appropriate fire signage, escape routes and corridors were clear of obstruction and the fire doors were unlocked allowing easy escape if needed. Fire extinguishers had been checked in August 2014 and the fire alarm was tested every two weeks. Regular fire drills were carried out.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Guidance from local commissioners was readily accessible.

We discussed with staff how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated by email and discussed with appropriate staff. We were told that staff meetings would be held if necessary, but no minutes were available for us to see. Staff we spoke with demonstrated an understanding and knowledge of NICE guidance and local guidelines. Staff described how they carried out assessments and explained how care was planned to meet identified needs.

We reviewed seven random patient records. In one case we found no evidence of a current diabetes check, where one ought to have been carried out. We asked staff how patients were reviewed at required intervals to ensure their treatment remained effective. For example, whether patients with diabetes were receiving regular health checks and being referred to other services when required. We were told that due to difficulties with the new computer system staff were currently unable to run appropriate checks. The practice was mostly relying on a manual inspection of records to identify patients due for health checks or carrying out the checks opportunistically when patients attended appointments. Training on the new system and support from the CCG was on-going.

The practice provided data after the inspection that 67 patients (59% of patients on the diabetes register) had received an annual foot check and an eye check had been done for 20 of patients on the register (18%). The data also showed that 16 patients (41%) on the mental health register had completed annual physical health checks and three of the five patients with learning disabilities had received an annual follow up.

Those patients at high risk of admission to hospital were being reviewed during clinical consultations. There were multidisciplinary care plans in place so that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The change of the practice's computer system had presented difficulties to staff in monitoring information about people's care and treatment, and their outcomes. For example, staff were not currently able to use the system to identify patients who needed annual blood tests or annual health checks. The practice was relying on necessary tests and checks being identified and carried out opportunistically, when patients made appointments, or by manual checking of patients' records.

Following our inspection in July 2014, we had taken action against the practice as we judged it did not protect patients and others, against the risk, of inappropriate or unsafe care by means of the effective operation of systems designed to enable the practice to assess and monitor the quality of the services. A factor in this was that the practice could not provide evidence of any clinical audits being carried out. At this inspection, the practice showed us four initial clinical audits that had been undertaken. They related to Warfarin and Statins prescribing, Accident and Emergency attendance and patients' waiting time. The waiting time audit led to a trialling of extended afternoon surgery hours. However, none of the audit cycles had been completed to monitor or demonstrate changes since the initial audit. Staff told us the Warfarin audit cycle would be completed in May 2015 and the Statins audit cycle in June or July. We were told that there was an initial diabetic audit being done at the time of the inspection, and that an initial vaccinations audit was planned for June 2015.

The practice participated in the quality and outcomes framework (QOF), which is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

Are services effective?

(for example, treatment is effective)

The practice achieved 71.9% of the total QOF target in 2014, which was below the CCG average of 84.5% and national average of 93.5%. Specific examples where performance was worse than the CCG average included:

- Performance for diabetes related indicators, 50.7% (28.8% below the CCG average);
- Performance for mental health related indicators, 46.6% (33.6% below the CCG average);
- Performance for hypertension related indicators, 66.9% (16.6% below the CCG average);
- Performance for dementia related indicators, 71.4% (10.9% below the CCG average).

The practice's performance was better than the CCG average in some aspects of care, for example:

- Performance relating to epilepsy indicators, 100% (21.5% above the CCG average);
- Performance for heart failure indicators, 100% (11.3% above the CCG average);
- Performance related to palliative care 100% (19.4% above the CCG average).

The practice performed above the national average in achieving the 100% target for Quality and Productivity and Patient Experience results.

The practice's prescribing rates were generally similar to national figures, although we noted from data available that the rates for Non-Steroidal Anti-Inflammatory drugs was higher than average. Staff told us this was because many patients suffered arthritis or back problems. We saw the practice had a protocol for repeat prescribing which followed national guidance. They also checked routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice maintained a palliative care register, although at the time of the inspection there were no patients registered. The practice had a register of patients with learning disabilities with four patients currently registered. We saw evidence of multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw from patient records that annual reviews were also

undertaken for people with long term conditions, for example diabetes and heart failure. However, due to issues with the computer system, no data was available to show the percentage of reviews done in the last year.

Effective staffing

The practice staff included the GP, a healthcare assistant, practice manager and administrative staff. The practice was in the process of recruiting a nurse. Following the inspection, we were told that a nurse had been appointed in April 2015.

The doctor had been a sole practitioner for seven years, following the departure of his partners. He told us that he took very few holidays and was rarely absent due to sickness. On those occasions, locum doctors covered his work. We saw that he worked long hours from Monday to Friday and he told us he often came into the surgery on weekends to do paperwork. When speaking with us, the doctor acknowledged that he had a heavy workload and was in discussion with another doctor with a view to them joining the partnership. After the inspection, the practice told us that the doctor no longer saw patients on Fridays, when locums were employed as cover, unless there was a need for an urgent home visit. No new partner had joined as yet, but discussion was on-going.

Staff were up to date with attending mandatory courses such as annual basic life support and fire safety. The GP was up to date with their yearly continuing professional development requirements and had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff told us they had annual appraisals that identified learning needs from which action plans were documented. However, no completed appraisal forms could be found for us to see. Our interviews with staff confirmed that the practice was proactive in providing training, for example the health care assistant told us that they had been trained by the GP in phlebotomy, and a mentoring arrangement had been made for the newly appointed practice manager. The health care assistant had a job description and there was one available for an employed nurse. These outlined their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For

Are services effective?

(for example, treatment is effective)

example, on administration of vaccines, cervical cytology and phlebotomy. The administrative staff were “apprentices”, mostly employed on annual contracts, who had undergone a suitable induction process, including undertaking online training.

Working with colleagues and other services

The practice worked with other service providers to meet patient’s needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required.

Emergency hospital admission rates for the practice were relatively low at 9.4% compared to the national average of 13.6%. We saw that the policy for actioning hospital communications was working well in this respect. The practice had carried out audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings on a monthly basis to discuss patients with complex needs. For example, patients with learning disabilities, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. We saw record of a number of meetings. We saw care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to

enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients’ care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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. Staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it, for example, with making do not attempt resuscitation orders. The practice policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. We saw several plans that had been discussed at multidisciplinary meetings and people we spoke with confirmed they had been involved in devising their relative’s care plans. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient’s preferences for treatment and decisions. The practice was not able to provide details of how many plans had been reviewed to date. When interviewed, staff gave examples of how a patient’s best interests were taken into account if a patient did not have capacity to make a decision. Staff demonstrated a clear

Are services effective?

(for example, treatment is effective)

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

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture at the practice to use its contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. Patients told us the doctor always asked after their general wellbeing.

The health care assistant carried out initial health checks on newly-registered patients. The practice offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients within four weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice identified additional support to patients who needed it. For instance by providing to smoking cessation clinics and advice to obese patients. QOF data showed the practice scored 80.3% for smoking-related indicators (3.7% below the CCG average) and 100% for obesity-related indicators (the same as the CCG average).

The practice's performance for the cervical screening programme was 57.58%, which was below the national average of 81.88%. In the absence of a practice nurse, patients needing smear tests were being referred to the nearby walk in centre or family planning clinic. We were told that the low uptake for screening was in part due to cultural issues within the patient population. The practice nurse had been responsible for following up patients who did not attend. We were told after the inspection that a nurse had been appointed in April and was now carrying out the cervical screening. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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

- Flu vaccination rates for the over 65s were 65.26%, and at risk groups 49.58%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 50% to 64.4% and five year olds from 53.8% to 92.3%. These were below national averages.

We saw that there were very few children eligible for the immunisations at the practice.

Overall, the practice's QOF results relating to Public Health were similar to the CCG average.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015 comments left by patients on the NHS Choices website.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 82% of respondents described their overall experience of the practice as good or very good and 72% of respondents would recommend the surgery to someone new in the area. However, the practice was scored below average for its satisfaction scores on consultations with doctors and nurses.

- 82% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 82% said the GP gave them enough time compared to the CCG average of 81% and national average of 87%.
- 90% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%
- 82% said the nurse was good at listening to them compared to the CCG average of 89% and national average of 91%.
- 87% said the nurse gave them enough time compared to the CCG average of 90% and national average of 92%.
- 90% said they had confidence and trust in the last nurse they saw compared to the CCG average of 95% and national average of 97%

Patients had completed CQC comment cards telling us what they thought about the practice. We received 18 completed cards and the all were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, caring and understanding. They said staff treated them with dignity and respect. Five people highlighted that the staff were good at listening. One person said the current lack of a nurse at the practice had an impact on their care. We also spoke with five patients attending for appointments and a

representative of the Patient Participation Group. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in a consulting room. In one of the rooms, the examination couch was next to a frosted glass window. There were no curtains or blinds and some patients might feel exposed during a consultation. We mentioned this in our feedback at the end of the inspection and the practice stated that blinds or curtains would be put up as soon as possible. The room in question was used only occasionally, when a locum GP was working. In the other consultation room the examination couch was located in an adjacent curtained-off treatment annexe. One patient told us they did not feel comfortable with this, but no others commented about a lack of privacy during treatment. We noted that treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard from the corridor.

We saw that staff had signed records to confirm they would follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We observed the interaction between receptionists and patients during the day and noted staff were careful to discuss matters discreetly and privately. Several private rooms were available if patients wished to discuss matters away from the main reception area. Patient survey data showed that 83% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 82% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was

Are services caring?

also evidence of learning taking place as staff meeting minutes showed this has been discussed. People experiencing poor mental health were able to access the practice without fear of stigma or prejudice. All staff had received mental health awareness training and were able to deal sympathetically with all groups of people.

Care planning and involvement in decisions about care and treatment

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

- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 69% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and national average of 81%.

Patients we spoke with on the day were more positive, telling us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. One person said the staff were generous with their time and never rushed. Two others said that staff encouraged them to ask as many questions as they liked. Another person told us that they and their relative, an older person, with long term health conditions had been very involved in drawing the relative's care plan. Patient feedback on the comment cards we received was also positive and aligned with these views.

Children were treated in an age-appropriate way. Two patients told us staff were very gentle and caring with their children, maintaining good eye contact and speaking directly to them.

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 area informing patients this

service was available, but none were in languages other than English. There was a self-check-in screen, with various languages available. One of the receptionists was a Bengali-speaker.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were generally positive about the emotional support provided by the practice. For example:

- 79% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 71% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.

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

We asked the staff about the comparatively low figure relating to patients experience of nurses at the practice. They told us that this could be due to the prolonged absence of an employed nurse at the practice, with the duties being covered by agency nurses. The practice had appointed two nurses over the past year, but both had left, one due to ill health and the other for personal reasons. A further recruitment process was underway. Following the inspection, the practice confirmed to us that a nurse had been appointed.

Notices and information leaflets in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's 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.

Staff told us that if families had suffered a 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. None of the patients we spoke with on the day had had a bereavement.

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 generally responsive to patients' 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. However, two of the patients we spoke with mentioned that the lack of a female doctor being an issue and that in some circumstances they might be reluctant to see the male GP at the practice. Staff confirmed that the matter had been raised by patients in the past. The doctor told us that if a female patient asks to see a female doctor they would be referred to the local walk in centre or Accident and Emergency. The practice provided oral contraceptives only. Patients using intrauterine devices (IUDs) were referred to a nearby family planning clinic. At the time of the inspection, there was a female health care assistant at the practice, but no nurse in post. The practice later told us that a female nurse had been appointed in April.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients, but access to online and telephone translation services were available if they were needed. One of the patients we spoke with, for whom English was a second language, was not aware of the translation service being available. Multi-language information about health care services could be accessed via the practice website. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

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

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. People were easily able to register at the practice, with registration forms available on the practice website together with information explaining the registration process.

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

Access to the service

The practice opening hours were 8.00am to 6.30pm Monday, Tuesday, Thursday and Friday and 8.00am to 8.00pm on Wednesday. Lunch hours were 1.00pm to 2.00pm. The practice did not open after lunch on Wednesday until 5.00pm, to allow for training and staff meetings. Consulting hours were 8.00am to 11.30am Monday to Friday; 3.00pm to 6.30pm on Monday, Tuesday and Friday; 5.30pm to 8.00pm on Wednesday and 5.00pm to 6.30 pm on Thursday. Consultations were 15 minutes long in the morning and 10 minutes during the afternoon session. Eight emergency slots of 10 minutes had been made available daily. Home visits were made during the day between the morning and afternoon consulting sessions.

The practice had opted out of providing out-of-hours (OOH) services and referred caller to the local OOH provider when closed. There was also information provided to patients regarding the nearby walk in centre, a service available to all patients which opened seven days a week, and regarding the NHS 111 service.

Comprehensive information was available to patients about appointments on the practice website. This 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, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Are services responsive to people's needs?

(for example, to feedback?)

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

- 77% were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 96% said the last appointment they got was convenient compared to the CCG average of 87% and national average of 92%.
- 75% described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 73% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 56% and national average of 65%.
- 94% said they could get through easily to the surgery by phone compared to the CCG average of 82% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. Patients told us they could make routine appointments within a few days and they confirmed that they could see a doctor on the same day if they felt their need was urgent. Comments cards received from patients also stated that routine appointments could be obtained within three to five days.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. Home visits were available to those patients who needed one. Extended hours enabled families with children to attend before or after school and provided suitable appointment times for working age patients and students.

Appointments could be booked online and repeat prescriptions could be ordered by patients who had registered to use the online facility and by telephone. New patient registration forms were also available on the practice website.

Listening and learning from concerns and complaints

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

We saw that information was available in the reception area and on the practice website to help patients understand the complaints system. Not all of the patients we spoke with were aware of the process to follow if they wished to make a complaint and none had ever needed to make a complaint about the practice. The practice monitored comments and reviews patients had left on the NHS Choices website and we saw that it responded to all submitted over the past 12 months. The practice had received only three complaints in the last 12 months. These had been appropriately handled, dealt with in a timely way, openness and transparency.

The practice invited comments and suggestions via its website and the practice leaflet. A suggestion box was located in the reception area, and was regularly checked. The practice manager recorded any submitted and discussed them with the doctor. The practice had also started the NHS Friends and Family survey. We saw 15 completed cards, and noted all were positive in the comments about the service.

Are services well-led?

Requires improvement 

(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 objectives were set out in its statement of purpose, “This Practice is dedicated to achieving and maintaining a high quality of care designed to meet the needs of our patients. To provide a high quality and confidential service to all patients regardless of age, sex, marital status, pregnancy or maternity status, race, ethnicity, disability, sexual orientation, gender, religion or belief.”

We spoke with three members of staff, who understood and supported the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern practice activities. We looked at 26 of these policies and procedures. We saw that staff signed an acknowledgement form to confirm they had read the policies. Examples included an infection control policy dated June 2014, Fire safety dated October 2014, Emergency drugs, dated July 2014 and cervical screening dated January 2015. However, there were some, such as the health and safety policy, chaperone policy, repeat prescription and vaccine fridge procedures were in need of review. We discussed this with staff who agreed to prioritise the review of all policies and procedures.

Staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had started using a new clinical computer system five months prior to the inspection. Staff were having difficulty using it effectively to properly assess, monitor and improve the quality and safety of the service, or to assess, monitor and mitigate the risks relating to the health and welfare of patients. The practice recognised that training for effective use of the new clinical computer system was needed and this was on-going at the time of the inspection.

The practice was making some use of the Quality and Outcomes Framework to measure its performance (QOF is

a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). However, staff were experiencing difficulties in processing QOF data, which had previously been the responsibility of the practice nurse. The QOF data for the practice indicated that it was not performing in line with national standards. The practice achieved 71.9% of the total QOF target in 2014, which was below the CCG average of 84.5% and national average of 93.5%.

The practice had introduced a programme of clinical audits which would be used to monitor quality and systems to identify where action should be taken. The practice told us of plans to complete the audit cycles and carry out further audits on identified themes. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice identified, recorded and managed health and safety risks. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. We saw that daily safety check lists were completed. Staff told us there were regular staff meetings where governance issues, performance, quality and risks were discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness, which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook.

Leadership, openness and transparency

The doctor has been a sole practitioner since the other GP partners left seven years ago. The practice manager had recently been appointed, having worked at the practice as an administrator. Staff told us that the doctor and practice manager were visible in the practice and staff told us that they were approachable and always take the time to listen

Are services well-led?

Requires improvement 

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

to all members of staff. They told us they were involved in discussions about how to run and develop the practice and to identify opportunities to improve the service delivered by the practice.

We saw from minutes that staff meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported.

Seeking and acting on feedback from patients, public and staff

Following our inspection in July 2014, we had taken action against the practice as we judged it did not protect patients and others, against the risk, of inappropriate or unsafe care by means of the effective operation of systems designed to enable the practice to assess and monitor the quality of the services. Specifically, the practice had not established a Patient Participation Group and it did not routinely monitor or respond to patients' comment left on the NHS Choices website. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

At this inspection, we saw that the practice had taken steps to set up a PPG and we met with one of its representatives. They were positive about the role and told us they felt engaged with the practice. They had asked the doctor to identify guidance and support in setting up the PPG and this was being provided. The PPG had initially met in September 2014, but had not met since. However, we saw that efforts had been renewed and another meeting was

planned a few weeks after our inspection. The practice later sent us the minutes of the meeting that had taken place on the 17 March. We saw that five patients had attended and the next meeting was scheduled for May. From the minutes, we saw that the PPG had discussed implementing a survey of patients and thought was being giving to formulating an agreed questionnaire. The PPG was advertised on the practice website, with more patients being invited to take part and a leaflet was available in the reception area. Minutes of the initial meeting were also available on the website. We also noted that the practice was now monitoring patients' comments on NHS Choices and was responding appropriately.

The practice had also gathered feedback from staff through generally through staff meetings and discussions. 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 in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They told us that they had regular appraisals, but could not provide us with evidence of any being done in the last year. Staff told us that the practice was supportive of training, but the identified needs for training in use of the new computer system had not been addressed. The practice manager had been recently appointed and the practice had made arrangements for them to be mentored by the manager from another practice.

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 Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>We found that the provider did not have systems or processes established and operating effectively to enable them to assess, monitor and improve the quality and safety of the service, or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.</p> <p>Specifically, staff had not been given sufficient training for them to make full and effective use of the practice's clinical computer system, to monitor patients' health and welfare needs and patient outcomes.</p> <p>This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>Regulation 17 (1), (2) (a), (2) (b) and (2) (c).</p>