Dr Jedth Phornnarit

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Dr Jedth Phornorrit provides primary care services at the Garway Medical Practice in West London. The practice provides care to a diverse local community of approximately 4500 patients. Services provided include antenatal care, child health and immunisation, chronic disease management, counselling, cognitive behavioural therapy and end of life care. The service is not available out-of-hours or at the weekend.

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

We carried out an announced inspection of the service on 14 May 2014. We spoke with eight patients attending the practice on the day of the inspection and collected six comment cards which patients had completed about the service in the days running up to the inspection.

The practice provided a safe service with systems in place to manage risks associated with infection control, medicines management, staff recruitment, child protection and adult safeguarding and medical emergencies. There were mechanisms to investigate and learn from incidents and complaints. The practice provided an effective service. Patients' needs were assessed and treatment and referral patterns were in line with current guidelines and best practice. Staff participated in collaborative clinical audits and external peer group meetings and used this evidence to improve.

Patients told us the service was caring. Most patients we spoke with were happy with the service they received at the practice. They said they were involved in decisions about their treatment. We observed that reception staff were usually polite although on occasion their interactions were less positive. The practice was responsive to the needs of its patients. The practice provided services tailored to particular patient groups, routinely booked interpreters for patients and had extended its opening hours. Patients were able to access appointments when they needed them although some patients told us they had to wait several weeks to book an appointment with their preferred doctor. The practice did not yet enable patients to book appointments online. The practice promoted health and prevention of illness but written information for patients tended to be available in English only.

The service was well-led in some respects but some areas needed improvement. The practice ethos was to put patients first and provide a high quality service. There were governance arrangements in place and an open reporting culture. However, we found that incident reports and an in-house cytology audit were poorly documented. We were also concerned that some clinical incidents might be missed for review because the system for collating them was not robust. The practice had not developed an in-house audit plan and was not yet exploiting the full potential of its information technology for quality assurance. The practice benefitted from an active patient participation group and acted on patient feedback. However members of the patient participation group were concerned that communication was sometimes difficult. The practice did not have a development plan for longer term growth and had not carried out any succession planning despite a number of doctors leaving.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Most aspects of the service were safe. The practice learned from incidents to improve the safety of the service although incident recording was not always robust. Lessons learned were discussed at the weekly clinical team meeting and followed up with changes to practice if appropriate. The practice staff were aware of procedures to protect children and vulnerable adults from the risk of abuse and they raised any concerns without delay. The practice was clean and there were systems in place to reduce the risk and spread of health acquired infection. Medicines were managed safely in relation to the prescription and repeat prescription procedures, storage of medicines and follow-up of patients following hospital discharge. Staff were trained to respond to medical and other emergencies and the practice was equipped with emergency medical equipment which was routinely checked. Staff were recruited safely.

Are services effective?

The service was effective although the practice made limited use of audit to assess and improve the service. Patients' needs were assessed and treatment and referral was in line with current guidelines and best practice. The practice worked in collaboration with other health and social care professionals to provide integrated patient care. There were appropriate arrangements in place to monitor review, and improve performance. The practice participated in external peer group meetings and used this evidence to improve. The clinical staff received an annual appraisal and revalidation as required. The practice had also recently made arrangements to provide all administrative staff with an annual appraisal. The practice promoted health and prevention and provided patients with information, advice and guidance. Written information tended to only be available in English.

Are services caring?

The service was caring but we observed both very positive interactions and occasional shortcomings in the way the receptionists interacted with people. Most patients were positive about the service. These findings were echoed in the practice's own patient survey and the national patient survey 2013. Several patients commented that staff treated them with dignity and respect and they felt involved in their care. The arrangements for ensuring patient privacy and confidentiality were effective. Patients were

asked for their consent and the staff acted in accordance with their wishes. The practice had an active patient participation group which met regularly and gathered feedback from a wider range of patients about the service.

Are services responsive to people's needs?

The practice was responsive to the needs of its patients. The practice took part in local enhanced schemes and projects to provide effective services to particular patient groups and had identified mental health as a local priority. There was good collaborative working between the practice and other health and social care services which helped to ensure patients' needs were met. Patients requiring specialist investigation or treatment were able to use the "Choose and Book" scheme to book a convenient first appointment and the practice staff supported patients if they needed help with the referral process. The practice routinely booked interpreters for patients whose first language was not English. Patients were able to access appointments when they needed them although patients told us they had to wait several weeks to book an appointment with their preferred doctor. This situation had been exacerbated by a number of doctors leaving and the use of locum staff. The practice learned from patients' experiences, concerns and complaints to improve the quality of care.

Are services well-led?

The service was well-led in some respects but some areas needed improvement. The practice ethos was to put patients first and provide a high quality service. The staff had clearly defined roles and responsibilities and were positive about the quality of leadership in the practice. There were governance arrangements to monitor risk and performance and an open reporting culture. The practice collaborated with other practices and the clinical commissioning group to understand its performance. However, we found that incident reports and an in-house audit were not systematically documented. We were also concerned that some incidents might be missed for review because the system for collating them was not robust. The number of patients using the service had recently declined and a number of doctors had left the practice. The practice did not have a development plan and had not done any long term succession planning to address these issues although we were told that the practice intended to expand. Members of the patient participation group were concerned about communication with the practice and described recent meetings as difficult. We found that the practice was responsive to feedback from the group and had made improvements to the service.

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 was responsive to the needs of older patients and carers. The practice encouraged all eligible older people to attend the practice for a health check and have the flu vaccination. The practice had improved the information it produced for patients about the referral process.

People with long-term conditions
The practice cared effectively for people with long term conditions. The practice was performing in line with national and local targets for a range of conditions. The practice made clinical staff aware of alerts about relevant guidelines. The practice operated a 'case management' system for patients with complex needs in the local community.

Mothers, babies, children and young people
The practice offered a range of services for mothers and babies and was meeting national targets in relation to primary care services for children. Staff understood their responsibilities in relation to safeguarding children and acted when they had concerns.

The working-age population and those recently retired
The practice operated with extended opening hours on two evenings a week. However the practice could do more to make the service accessible to people with work or other daytime commitments.

People in vulnerable circumstances who may have poor access to primary care
The practice ensured primary care services were available to people in vulnerable circumstances. The practice had identified patients with learning disability as an area for further development.

People experiencing poor mental health
The practice had developed some in-house services to support people with mental health problems in response to local need.

Summary of findings

What people who use the service say

We reviewed the most recent national patient survey results for this practice; information published on the NHS Choices website; the practice's own patient feedback survey which included interviews with over 100 patients, and interviews and comments we obtained from patients during the inspection.

Most patients we spoke with were happy with the service they received at the practice and commented positively on the doctors in particular. They said they were fully involved in decisions about their treatment and did not usually feel rushed. Patients said the premises were clean and well laid out. The results of the 2013 national patient survey for the practice showed that 75% of responding patients would recommend the practice to others.

Patients were more critical of the time it took to obtain an appointment with a doctor of their choice and the late running of surgeries. Patients said they sometimes had to wait up to an hour after their appointment time. The lead GP told us they had increased the length of some appointments to address this problem. We spoke with some patients who said it was important to see a doctor who was familiar with them and their condition. These patients said the recent departure of several doctors at the practice had a negative impact on their experience of primary care. Recent comments from patients on the NHS Choices website echoed these concerns.

The practice benefitted from an active patient participation group which had collected and analysed patient feedback and brought issues to the attention of the practice. The practice had taken action to address patient concerns.

Areas for improvement

Action the service MUST take to improve

The practice:

- had a system for reporting, investigating and learning from incidents but incident reports were not always collated in a transparent way and we were not assured that all relevant incidents were included in the clinical meetings for review
- conducted in-house audits of care but did not have an annual audit plan prioritising aspects of the service for review. We were told about one recent audit and how this had been influential in changing the service. However the provider was unable to show us any detailed written analysis and results for this audit. Documented analysis would allow the findings to be checked and would be useful for the staff for future reference.

Action the service COULD take to improve

- The provider did not yet offer patients the facility to book appointments online
- Reception staff were on occasion observed to interact poorly with patients arriving at the practice. Receptionists told us they had not had structured opportunities to learn how to manage challenging situations and said they would benefit from this.
- The patient participation group reported that it was sometimes difficult to communicate effectively with the practice
- The practice provided little written information for patients in languages other than English
- The practice had not developed a plan for the longer-term development and growth of the practice and had not carried out succession planning in advance of doctors leaving. The practice had also not explored whether there were any underlying issues with the working environment that had contributed to the recent turnover of medical staff.

Dr Jedth Phornnarit

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector**.** The team included a CQC pharmacy inspector, a GP and a practice manager. They were all granted the same authority to enter Dr Jedth Phornnarit's practice as the CQC inspectors.

Background to Dr Jedth Phornnarit

Dr Jedth Phornnarit provides primary care services from the Garway Medical Centre to approximately 4500 people living in the surrounding areas of Bayswater and Paddington in West London. The population is ethnically, culturally and socioeconomically diverse and characterised by a relatively high proportion of people moving into and out of the area. The practice is open Monday to Friday with extended opening hours on two evenings a week. Services provided include antenatal care, child health and immunisation, sexual health, chronic disease management, counselling, cognitive behavioural therapy and end of life care. The practice maintains a website with details of opening times, the staffing team and services provided.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the service and asked West London Clinical Commissioning Group, NHS England and the local Healthwatch to share what they knew about the service. We carried out an announced visit on 14 May 2014.

During our visit we spoke with a range of staff: the lead GP partner, a locum GP, the practice manager, the practice nurse, the health care assistant, the medical secretary and a receptionist.

Detailed findings

We observed the physical environment and reviewed practice documents including various policies, minutes of the clinical team meeting, recruitment and training records, the patient participation group's annual report and the most recent practice survey results.

We also spoke with patients who used the service and observed how people were greeted in reception.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective although the practice made limited use of audit to assess and improve the service. Patients' needs were assessed and treatment and referral was in line with current guidelines and best practice. The practice worked in collaboration with other health and social care professionals to provide integrated patient care. There were appropriate arrangements in place to monitor review, and improve performance. The practice participated in external peer group meetings and used this evidence to improve. The clinical staff received an annual appraisal and revalidation as required. The practice had also recently made arrangements to provide all administrative staff with an annual appraisal. The practice promoted health and prevention and provided patients with information, advice and guidance. Written information tended to only be available in English.

Our findings

Promoting best practice

Best practice standards and guidelines were followed in the assessment and planning of patients' healthcare needs. Staff were encouraged to keep their professional skills and knowledge up-to-date. For example, the clinical staff were aware of and followed current national guidelines on antibiotic prescribing. One patient told us that the doctor had explained to them why antibiotics were inappropriate for a viral infection. They had found this explanation helpful.

The practice followed national and locally agreed policies for referrals, for example, referring patients with cancers within two weeks. The practice had an electronic referral template in place. This enabled the doctors to systematically obtain and assess the information needed to make a referral to the appropriate specialist. The practice also employed a medical secretary whose role included supporting patients with the referral process.

The practice was meeting national and local targets for the management of a range of chronic conditions. Clinical staff received alerts about new or updated clinical guidelines on the management of various conditions. The practice followed 'integrated pathways' of care for long term conditions such as asthma and chronic obstructive pulmonary disease (COPD).

Management, monitoring and improving outcomes for people

The practice participated in clinical audit. The practice took part in local commissioning group and peer group meetings to benchmark performance data and share good practice across local practices. This included work on inappropriate outpatient referrals, avoidable A&E attendances and emergency admissions. The practice had conducted a recent audit of cytology following a particular concern and had re-audited to check for improvement. This audit had resulted in a number of actions to improve the quality of care. The practice had not developed an in-house clinical audit plan other than audit work required to achieve the Quality and Outcomes Framework and other contractual targets and meet individual doctors' appraisal and revalidation requirements.

Are services effective?

(for example, treatment is effective)

Staffing

The practice was staffed by the lead GP partner and a part-time salaried GP they also used a locum GP to cover staff absence and busy periods. The practice employed a full-time practice nurse, a health care assistant, administrative and reception staff and a practice manager.

The doctors underwent annual appraisal and revalidation as required but the administrative staff had not had an appraisal for several years. The practice manager had very recently reintroduced an appraisal system for all staff members and had begun to implement this. The administrative staff team was stable and these staff members spoke very positively about the leadership of the GP partner and practice manager and described the practice as a good place to work.

Working with other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure a joined up approach for patients. There were clear referral pathways and the practice was able to refer patients to a wide range of specialist services available in the local area.

Staff described having positive relationships with community health professionals, for example, health visitors who led a weekly baby clinic on the premises. The doctors also ran a weekly multidisciplinary team meeting to manage the care of patients with complex needs and avoid the need for unnecessary hospital admissions. This was attended by practice staff, community health staff and specialist consultants as appropriate.

The practice had secured the services of a volunteer "primary health care navigator" and we were told that this person had helped patients to access a wider range of community services and advice for example legal and employment services.

Health, promotion and prevention

The practice promoted patient's health and wellbeing. There was a wide range of posters and leaflets in the waiting area although most of this information was only in English. All new patients received a health check and advice. The practice participated in national population and child health screening and immunisation programmes.

The health care assistant's role included health promotion and they provided advice for patients on lifestyle factors such as smoking and diet. The patient participation group had also explored the possibility of promoting health education in partnership with the neighbouring school.

Are services caring?

Summary of findings

The service was caring but we observed both very positive interactions and occasional shortcomings in the way the receptionists interacted with people. Most patients were positive about the service. These findings were echoed in the practice's own patient survey and the national patient survey 2013. Several patients commented that staff treated them with dignity and respect and they felt involved in their care. The arrangements for ensuring patient privacy and confidentiality were effective. Patients were asked for their consent and the staff acted in accordance with their wishes. The practice had an active patient participation group which met regularly and gathered feedback from a wider range of patients about the service.

Our findings

Respect, dignity, compassion and empathy

Most patients we spoke with or who completed a comment card described the service as caring and compassionate. The practice's own survey found that most patients thought they were treated with dignity and respect. In the 2013 national patient survey for the practice, 72% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 76% said the last nurse they saw or spoke to was good at listening to them.

During the inspection we saw that patients were usually, but not always, greeted politely by the staff. We saw some excellent interactions between staff and patients. For example, we saw the receptionists and the health care assistant taking care to explain practice procedures in a way people could understand. When people arrived with questions or issues we saw that the staff took the time to ensure these were resolved. We also saw excellent interaction between reception staff and a patient with learning disability. The receptionists gave the patient time to engage, spoke with direct eye contact and were warm and welcoming in manner

However, we did observe occasional instances of poor communication. For example, a patient was ignored without any explanation while a staff member stopped to answer the telephone. The receptionists were experienced but had not had structured opportunities to develop their skills, for example, in managing challenging situations. They told us they would find this sort of learning opportunity useful for their role.

The practice took care to protect patient's privacy. The waiting area was located away from the reception desk insofar as possible. Receptionists took care not to repeat patients' date of birth or discuss confidential information over the phone in a way that would allow others to identify the person. The receptionists told us that sometimes patients wanted to discuss something more privately and they could take them to a quiet area. There was no written notice informing patients that this was possible but the receptionists said they were sensitive to this situation and offered it when appropriate. Treatment rooms were equipped with curtains to help protect patients' privacy during physical examination. Consultations could not be overheard from the waiting area. Staff ensured that confidential information was not openly visible to others.

Are services caring?

Involvement in decisions and consent

Most patients said they had been involved in decisions about their treatment and the doctor gave them time to ask questions. Patients were happy with the information they had been given and said their treatment had been explained to them. Two patients said they had previously felt rushed by a doctor who had not listened but their more recent experiences with different doctors had been positive. In the 2013 national patient survey for the practice, 80% of patients said the GP they saw was good at explaining tests or treatment but only just over half felt the GP was good at involving them in decisions.

The clinical staff sought verbal consent from patients before any examination, treatment, referral or immunisation. The doctors told us they were sensitive to people's different cultural and religious beliefs and the importance of obtaining patients consent in this context. The practice used interpreters to ensure patients were able to give informed consent to care. Clinical staff told us they tried to involve children in their care and would obtain a child's consent if they were able to understand what was being proposed.

The practice had an active patient participation group. The group met regularly and gathered feedback from patients more widely, for example, helping to develop and run the practice survey. The most recent survey had been carried out in February 2014 by interviewing 120 patients providing valuable feedback to the practice. These interviews were more representative of the practice population than previous surveys.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to the needs of its patients. The practice took part in local enhanced schemes and projects to provide effective services to particular patient groups and had identified mental health as a local priority. There was good collaborative working between the practice and other health and social care services which helped to ensure patients' needs were met. Patients requiring specialist investigation or treatment were able to use the "Choose and Book" scheme to book a convenient first appointment and the practice staff supported patients if they needed help with the referral process. The practice routinely booked interpreters for patients whose first language was not English. Patients were able to access appointments when they needed them although patients told us they had to wait several weeks to book an appointment with their preferred doctor. This situation had been exacerbated by a number of doctors leaving and the use of locum staff. The practice learned from patients' experiences, concerns and complaints to improve the quality of care.

Our findings

Responding to and meeting people's needs

The practice provided a service to a diverse population with a wide range of needs. Most of the patients we spoke with and who completed comments cards said the practice met their healthcare needs. This was confirmed in the practice's own interview surveys conducted by the practice's patient participation group (PPG) in February 2014. The practice responded to this survey by developing an action plan. We also saw that the practice had made progress in addressing many of the actions identified from the previous year's survey.

The practice was able to demonstrate an understanding and awareness of the needs of the local population including people in vulnerable circumstances. The practice had identified mental health needs as being a local priority following an increased pattern of demand in the practice and discussion with the local commissioning team. There was an in-house counsellor and psychiatric nurse who could provide cognitive behavioural therapy. The practice also hosted a 'primary care navigator' who was funded through Age UK and the West London Clinical Commissioning Group. This person supported patients by directing them to relevant professionals and agencies including voluntary and local authority services outside the practice.

The practice engaged with commissioners and other providers to co-ordinate and provide integrated care to meet the needs of the different patient groups it served. The practice participated in some Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups and provided shared ante-natal care with the local community midwifery service.

There were appropriate arrangements in place for obtaining, communicating and following up the results of diagnostic tests. Patients were able to use the national electronic 'choose and book' service to choose a suitable time and location for their first appointment. The practice employed a medical secretary to help facilitate the referral process and we were told this was particularly helpful for older patients.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The majority of the practice population was of working age. The practice operated with extended opening hours two evenings a week and it was possible to book appointments several weeks in advance. The practice scored relatively highly on access to appointments in its results from the 2013 national patient survey. We received mixed patient feedback about access to the service. Some patients told us they had to wait several weeks to see the doctor of their choice. Some patients with longer term conditions told us this had led to a lack of continuity which had adversely affected their experience of care at the practice. Patients who did not mind which doctor they saw said they were able to book an appointment without any problems. The practice was not yet able to offer patients the facility to book appointments online.

Some patients told us that they sometimes had to wait a long time at the practice for their appointment. These findings were echoed in the practice's own survey and comments made to the NHS Choices website.

Many patients using the service did not speak English as a first language. When patients called to make an appointment the receptionists routinely checked if they wanted the practice to book an interpreter to help with any communication needs. We observed the receptionists checking this with people.

The practice had a policy of never turning new patients away regardless of their circumstances or status. The practice received referrals from a local domestic violence service and also served homeless families staying in nearby temporary housing.

Concerns and complaints

The practice had a complaints process in place. Complaints were documented, investigated and discussed in the weekly clinical meeting. We reviewed the complaints the practice had recently received. These had been managed in line with practice policy.

The practice kept complainants informed of the progress of the investigation and the outcome. For example, one person had complained about an entry in their patient records. The doctor had considered the patient's views but, in this case, judged that the entry was clinically important. They had written to the person explaining this. They had also added a note to the patient record to highlight the issue that the patient had concerns about. We saw that letters to complainants were written clearly and included an apology and an explanation when a complaint had been upheld.

Are services well-led?

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

Summary of findings

The service was well-led in some respects but some areas needed improvement. The practice ethos was to put patients first and provide a high quality service. The staff had clearly defined roles and responsibilities and were positive about the quality of leadership in the practice. There were governance arrangements to monitor risk and performance and an open reporting culture. The practice collaborated with other practices and the clinical commissioning group to understand its performance. However, we found that incident reports and an in-house audit were not systematically documented. We were also concerned that some incidents might be missed for review because the system for collating them was not robust. The number of patients using the service had recently declined and a number of doctors had left the practice. The practice did not have a development plan and had not done any long term succession planning to address these issues although we were told that the practice intended to expand. Members of the patient participation group were concerned about communication with the practice and described recent meetings as difficult. We found that the practice was responsive to feedback from the group and had made improvements to the service.

Our findings

Leadership and culture

The GP partner took the clinical and corporate lead for the practice and was supported in this role by the practice manager. The management structure was clear to staff and staff were positive about the quality of leadership in the practice. Staff consistently told us they were committed to providing care that was high quality and their ethos centred on the needs of individual patients. We were told that the practice planned to expand but the practice did not have a development plan for growth despite the number of patients using the service declining over recent months.

The patient participation group had raised various issues with the practice particularly in relation to the loss of individual members of clinical staff over a period of time. The practice had responded for example by appointing new and locum doctors but we found that their approach tended to be reactive rather than proactive. For example, four doctors had retired but there had been little in the way of long-term succession planning to manage the impact of their departures before they occurred.

Governance arrangements

The practice had governance arrangements in place. Assurance for quality and safety was the responsibility of the GP partner and managed through the weekly clinical meetings which covered incidents, audits, complaints, safeguarding and other monitoring information. However we found that while clinical meeting notes were available, supporting documentation was not always accessible or available. For example, we were told about a recent cytology audit and how this had influenced the service but the audit itself was not readily available in written form for review. Documented analysis would allow the findings to be checked and would be useful for the staff for future reference.

Systems to monitor and improve quality and improvement

The practice was aware of how it was performing, for example, in terms of patient feedback and on a range of patient outcome measures provided by the clinical commissioning group comparing performance across local practices. We were told that a representative from the practice usually attended clinical commissioning group

Are services well-led?

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

meetings to share information and this was a useful exercise. The practice also participated in local data quality and auditing exercises, for example on prescribing and took account of the results.

However, we found that the practice relied heavily on standardised benchmarking and had not developed its own in-house audit programme. The GP partner and practice manager were confident their quality systems worked well but found it difficult to provide us with evidence of this. The practice had invested in information technology but was not yet making the most of the computer system by, for example, exploiting the audit and monitoring opportunities it presented.

Patient experience and involvement

The practice and its patients benefitted from an active patient participation group. The group met every two months and had identified a number of issues and how these were impacting on patients. The group was persistent in following-up actions with the practice. The GP partner and practice manager attended the meetings.

During the inspection, the co-chairs of the patient participation group and several members contacted us to express concern about some aspects of the practice, particularly the difficulty in seeing a preferred doctor within a reasonable time and maintaining continuity of care. They reported that the practice did not always take their views on board and the meetings were sometimes difficult for this reason.

However, we found that the practice had responded to the group's concerns for the benefit of patients. The GP partner had taken a short 'sabbatical' from clinical practice to review management systems and address issues raised by the patient participation group. The practice had made progress on addressing actions identified through its patient survey, for example recruiting a female doctor.

Staff engagement and involvement

Staff met regularly to discuss and reflect on the service. The practice closed each lunchtime which provided a daily opportunity for staff to discuss and review any issues. We noted that the practice had undergone a high turnover of doctors with seven doctors leaving over the previous seven years. Four of these doctors had retired. Three had left to pursue other opportunities, for example, overseas work. The GP partner told us that they were sure the practice was a positive working environment for doctors. However, the practice had not conducted exit interviews with departing doctors or carried out any other review of the practice environment and working culture to ensure there were no underlying problems of this nature. It was difficult to assess the quality of clinical mentoring and engagement in the practice during the inspection as the salaried doctors were relatively new.

Learning and improvement

The practice clinical team met weekly and considered any incidents, complaints and feedback, audits and other changes to guidelines or policy. The meeting minutes and staff interviews indicated an open reporting culture. However, documentation about incidents was not stored centrally. Instead, written summaries were added to the agenda of the next clinical team meeting as they arose. One of the doctors told us they had recently reported an incident but it had not yet appeared on the meeting agenda and they were not sure why. We were concerned that without a more systematic collation system, some incidents might be missed. We saw evidence from the meeting notes that incidents discussed at the meeting were investigated and any actions followed-up for improvement.

Identification and management of risk

The practice did not keep a written risk register. As a small practice, the practice considered this unnecessary. However there was a business continuity plan and separate policies and procedures covering various risks. The practice had recently experienced flooding and had to close the building for a period. The business continuity plan had been put into action effectively and patient care had not been compromised.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice was responsive to the needs of older patients and carers. The practice encouraged all eligible older people to attend the practice for a health check and have the flu vaccination. The practice had improved the information it produced for patients about the referral process.

Our findings

The practice was responsive to the needs of older patients and carers. We were told that the local older population included a relatively high proportion of active patients who were keen to be involved in decisions about their care and understand different treatment options. The practice routinely offered patients over 75 a health check and a named GP in line with national guidance and encouraged older people to have the flu vaccination.

The practice employed a medical secretary whose role included oversight of the referral process. The practice had improved the written information given to patients about their referral and highlighted key contact information in yellow highlighter. Staff supported patients to follow up problems with referrals when they were not confident in doing this themselves.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice cared effectively for people with long term conditions. The practice was performing in line with national and local targets for a range of conditions. The practice made clinical staff aware of alerts about relevant guidelines. The practice operated a 'case management' system for patients with complex needs in the local community.

Our findings

The practice had effective systems in place to care for people with long term conditions. The practice was meeting national and local targets for the management of a range of chronic conditions. Clinical staff received alerts about new or updated clinical guidelines on the management of various conditions. The practice operated a 'case management' system for patients with complex needs in the local community. These patients were reviewed at a weekly multidisciplinary team meeting. The meeting was attended by practice staff, local community health staff and specialists with the aim of meeting patient's needs in the community and avoiding unnecessary hospital admissions. The practice followed 'integrated pathways' of care for long term conditions such as asthma and chronic obstructive pulmonary disease (COPD).

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice operated with extended opening hours on two evenings a week. However the practice could do more to make the service accessible to patients with work or other daytime commitments.

Our findings

The majority of the practice population was of working age. The practice operated with extended opening hours two evenings a week and it was possible to book appointments several weeks in advance. However, patients had to telephone or attend the practice in person to make an appointment. The practice did not yet offer online appointments which this group of patients might find particularly convenient.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The practice ensured primary care services were available to people in vulnerable circumstances. The practice had identified patients with learning disability as an area for further development.

Our findings

The practice had a policy of never turning new patients away regardless of their circumstances or status. The practice had a procedure in place so that new patients presenting with complex needs or in vulnerable circumstances would be directed to the lead GP partner or duty doctor. The practice received referrals from a local domestic violence service and also served homeless families staying in nearby temporary housing. Staff consistently told us they were committed to providing good care to patients whatever their circumstances.

The practice had identified that its register of patients with a learning disability seemed low and was likely to be inaccurate. We were told this was an area for improvement although the practice did not yet have plans in place to take this forward. The practice had recently invited a speaker from the local learning disability service to their staff meeting for an update which we were told had been helpful and raised awareness. During the inspection we saw an example of excellent interaction between reception staff and a patient with learning disability. The receptionists gave the patient time to engage, spoke with direct eye contact and were warm and welcoming in manner.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice had developed some in-house services to support people with mental health problems in response to local need.

Our findings

The practice had identified mental health as a high priority given the prevalence of mental health needs in the local area. As a result, the practice offered counselling and cognitive behavioural therapy sessions on the premises. We spoke with patients who were using the counselling service on the day of the inspection and they told us they found this very helpful. Patients were referred and signposted to specialist mental health care when this was required.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: Patients were not protected against the risks of inappropriate or unsafe care because the system in place to identify and analyse clinical incidents was insufficiently robust. The provider had also not developed an audit plan to ensure that it had sufficient audit data to assess and monitor the quality of its service. Regulation 10(2)(c)(i)(ii)