Dr Harminderjeet Surdhar

Quality Report

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

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Overall summary

Dr Harminderjeet Surdhar's practice at Five Ways Health Centre provides primary medical services for a local population of approximately 4000 patients in the local area.

As part of our inspection we spoke with patients, staff and various stakeholders such as managers of two local nursing homes where the practice provided support, the local Clinical Commissioning Group, Local Medical Council and Healthwatch to gain an understanding of the service provided. The feedback, where received about the practice, was positive.

Comments from patients showed that they were happy with the service received and that they were treated with respect by the staff. The practice was responsive to the needs of the patients. The practice service supported patients who may have difficulty accessing its services. There was an understanding of the population served by the practice and services had been provided to reflect the needs of the population and vulnerable groups. Patients we spoke with described a caring and supportive service which met their needs.

We looked at the care provided to six population groups. We found that the practice responded to the needs of these population groups. Older and vulnerable patients were supported to access the practice so that their health needs could be met. Those patients with long term conditions received regular reviews so that any changes in their condition could be managed. Working age patients were invited for health checks so any signs of early disease could be detected. Mothers and children were also supported in conjunction with midwifery and health visiting services.

We identified however that the practice did not have robust governance arrangements in place and was in in breach of the regulation relating to assessing and monitoring the quality of service provision. Systems in place did not effectively manage risks relating to the practice service.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements were needed to ensure the service was safe. Systems for ensuring the safety of patients who used the service were not always well established and robust. Gaps seen in the systems meant that we could not always be assured that risks to patients had been fully addressed. This included areas such as the management of incidents, infection prevention and control and health and safety issues affecting the practice.

Are services effective?

There were improvements the practice could make to ensure the service is effective. The practice had effective systems for monitoring and supporting patients with long term health conditions. Patients were supported by staff with appropriate skills and knowledge to support their needs. However, we found some shortfalls in relation to meeting the needs of patients who may not have the capacity to make decisions about their health care needs. Not all staff received regular formal support and supervision opportunities in their roles so that any concerns or learning needs could be identified.

Are services caring?

The service was caring. Patients told us that they received a caring service and were treated with dignity and respect. They felt involved in decisions about their care and treatment. The practice was sensitive to the needs of patients at the end of their lives and their families.

Are services responsive to people's needs?

The practice was responsive to the needs of the population it served. Patients were able to access the practice when needed and reasonable adjustments were made to remove barriers to the service experience by some patients. Complaints were responded to appropriately and in keeping with the complaints procedure in place at the practice.

Are services well-led?

Improvements were needed to ensure the service was well led. There was a high level of satisfaction with the service and patients felt they were listened to. However, the governance arrangements were not sufficiently robust to ensure risks to patients were identified and managed appropriately.

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
Older people were supported to access the service so that their health needs could be met. They received consistency of care through the main GP who got to know their specific health needs. The practice supported to care homes which were satisfied with the service they received.

People with long-term conditions
People with long term conditions had access to regular reviews of their health and were seen by staff who maintained their skills and knowledge in these areas. Patients with long term conditions told us that they felt looked after by the practice.

Mothers, babies, children and young people
The practice worked alongside midwifery and health visitors to provide care for mothers, babies, children and young people. Immunisation services were available at the practice. Young children were given priority in accessing the service.

The working-age population and those recently retired
Working age people were able to access services through extended opening times. Health checks and health screening was available so that any health issues could be identified and managed at an early stage.

People in vulnerable circumstances who may have poor access to primary care
Provision was made for vulnerable people to access the health service and have their health needs met. Support was available for those people with learning disabilities, drug addictions and homeless people.

People experiencing poor mental health
Patients with poor mental health were able to receive the treatment they needed from the practice. The practice also described supportive mental health services that they could refer to when needed. Support was also provided for patients with drug addictions.

Summary of findings

What people who use the service say

We spoke with eight patients who used the practice either in person or by telephone; this included two members of the practice's Patient Reference Group (PRG). The PRG is a way in which patients and GP practices can work together to improve the quality of the service provided. We also reviewed the 12 comment cards provided by CQC which had been completed by patients who had recently used the practice.

The majority of comments received from patients who used the practice were very positive. Patients told us that they were happy with the service received and that they were treated with dignity and respect. Staff at the practice were described as polite, caring and helpful. We spoke with managers from two care homes which the practice supported. Both managers told us they were satisfied with the support they received. One manager described the support as brilliant.

We received just one negative comment which was in relation to the management of a verbal complaint. The practice had no systems in place to manage such complaints. Three patients also told us that it was sometimes difficult making an appointment but they felt they would be seen if their concerns were urgent.

Areas for improvement

Action the service MUST take to improve

- The provider must develop effective systems to monitor the quality of service provision; identify and manage potential risks to patients who use the service, including those relating to health and safety; business continuity; infection control and staffing. Any areas for learning should be shared with staff to support service improvement.
- The provider must ensure robust systems are in place to protect patients and others from the risks of fire.
- The provider must remove the unused and unmaintained oxygen cylinders from the practice.

Action the service SHOULD take to improve

- Incident reporting should provide a clear account of the investigation undertaken and learning identified so that it may be shared among staff to minimise the risks of future re-occurrence.
- Emergency equipment should be stored in a place that is secure and accessible to staff when needed without the risk of potential delays.
- The practice should consider the availability of oxygen for use in an emergency situation.
- Implement systems for the formal hand over of duties to locum GPs.
- The practice should have clear and robust processes in place to ensure that any decisions made on behalf of a patient about their care and treatment are done so in the patient's best interest and in accordance with the Mental Capacity Act 2005.
- The practice should ensure robust systems are in place for the management of prescriptions to minimise the risk of unauthorised use.
- The practice should ensure robust infection control audits are carried out to ensure potential infection control risks are identified and acted on.
- The practice should ensure the alert system on patient records is working as intended to ensure key information about patients, such as those who are at risk, are readily available to staff.
- Policies and procedures should be dated and regularly reviewed to ensure staff are working to the latest guidance.
- The provider should bring to the attention of patients the complaints system so that any concerns they have about the practice can be easily raised.
- The provider should provide formal opportunities for all staff to discuss on an individual basis issues relating to their performance, work and training needs.

Dr Harminderjeet Surdhar

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP. The team also included a second CQC inspector, a practice manager and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Dr Harminderjeet Surdhar

Dr Harminderjeet Surdhar is a sole provider.

The practice is based at Five Ways Health Centre close to Birmingham City Centre. It covers a culturally diverse population of approximately 4,000 people. The practice is open Monday to Friday with the exception of Wednesday afternoon.

At the time of our inspection there were three GPs working at the practice. This included Dr Surdhar who worked full time and two locum GPs who were employed long term to cover a total of three mornings each week. The practice also employed a nurse practitioner who worked two long days each week. The practice was managed by a practice and business manager.

The practice has opted out of providing out-of-hours primary medical services to another provider.

Why we carried out this inspection

We inspected this out-of-hours 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 poor mental health.

Before our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 4 August 2014. During our inspection we spoke with a range of staff including a general practitioner,

Detailed findings

the business manager, the nurse practitioner and other clinical and administrative staff. We also looked at a range of documents that were made available to us relating to the practice.

We spoke with patients who visited the practice and observed how staff interacted with them. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice. We spoke with two members of the Patient Reference Group (PRG). PRGs are a way for patients and GP surgeries to work together to improve services and the quality of care provided.

Following our inspection we also spoke with the managers from two care homes where the practice provides support.

Are services safe?

Our findings

Safe track record

Performance information reviewed in relation to patient safety such as the Quality and Outcomes Framework (QOF) and General Practice Outcomes Standards (GPOS) indicated that safety issues at the practice were in line with expected standards. For example maintenance of equipment and prescribing of certain drugs. QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients. GPOS are a set of standards developed by clinicians to improve quality.

The practice had systems in place for recording incidents and events. Staff were aware of these systems and told us that they were encouraged to report incidents when they occurred. We saw reports of incidents that had occurred in the last year.

There was no clear overall picture of safety issues at the practice which included information from multiple sources such as incidents, complaints, comments, audits and other feedback. This would enable the practice to identify any emerging trends and any action needed to manage risks to safety. Issues relating to safety tended to be addressed in isolation.

Learning and improvement from safety incidents

The systems in place for reporting, recording and monitoring significant events at the practice were not robust. We saw incident reports that had not been fully completed. The reports showed that the immediate issue had been dealt with but action recorded had not demonstrated how the incident had been investigated or what learning had been identified. Staff told us that incidents were discussed with them individually and at team meetings. We saw that there had been an annual review of incidents during the last 12 months and that this had been discussed at the staff meeting but there was no evidence of any learning shared as a result of this.

We saw documented evidence to show that the practice responded to and acted on national patient safety alerts received. Patient safety alerts raise awareness among health care professionals of potential patient safety issues such as those relating to medicines or equipment. This enables health care professionals to take any necessary action to minimise any risks to patient safety. We discussed this with the GP who showed us that they received safety alerts regularly. They told us that they looked at these to see if any were relevant to the practice. The GP advised us that any action needed was discussed with the practice manager to take forward.

Reliable safety systems and processes including safeguarding

The practice had arrangements in place to protect patients from the risks of abuse. There were safeguarding policies in place for both patients and vulnerable adults. These provided information to staff to help them to recognise signs of abuse and what to do if they suspected abuse might be occurring. We saw certificates that showed that some staff had received training in safeguarding children and vulnerable adults. Due to the organisation of staff training records we could not easily verify that all staff had received the training, although members of staff we spoke with during the inspection confirmed they had received this training. We saw contact information for the local safeguarding authority, which investigates and acts on safeguarding concerns, displayed throughout the practice. This provided staff with information needed so that staff would know who to contact if they had any concerns that someone was at risk of harm.

There was a named lead for safeguarding concerns at the practice. We saw from training certificates that the lead GP had been trained to level 3 (the highest level for safeguarding children). We asked the GP about patients at the practice who might be at risk of abuse and how staff were alerted to this. The GP advised us that there were very few patients currently at the practice who was on the at risk register. We were advised that practice staff were made aware of patients on the at risk register by an alert placed on the patient's records. This enabled staff to be more vigilant to any issues arising. However, when we were shown an example of the alert it did not work on the first attempt, which may result in staff not being aware of patients at the practice who are at risk.

The GP told us that the practice had never had to make a safeguarding referral. We spoke with the GP about the clinic held by the controlled drugs worker, as part of the enhanced services provided at the practice. We discussed whether the social histories of patients attending this clinic were explored to determine whether there were any children involved. The GP advised us that this was not something that the practice had previously explored but they would take this further in future.

Are services safe?

We looked at some of the systems and processes in place at the practice to keep patients safe, such as health and safety monitoring. We found the practice premises which were opened two years ago were in good condition. However, some of the checks undertaken to continuously monitor the maintenance of the premises were not robust. The fire risk assessment was out of date and the fire compliance certificate had expired. A safety audit completed in February 2013 had identified actions required. This safety audit had not shown that the actions had been completed and there had been no follow up audit. The fire precautions log book was not kept up to date. For example checks of the automatic door releases were last recorded in February 2013. The weekly fire alarm check was last carried out in April 2014. We also saw conflicting information in different files which related to checks on emergency lighting and with the records of fire drills.

Monitoring safety and responding to risk

There were arrangements in place to enable staff to respond to a medical emergency. Staff received training in basic life support so that they would know what to do if a medical emergency arose. The emergency equipment and medicines were stored in the nurse practitioners room. All members of staff we spoke with knew where to find these and could access this room. However, storage of emergency equipment in the nurse's room could give rise to difficulties if the nurse was undertaking a patient consultation and procedure when the emergency equipment was needed.

The practice nurse advised us that they did not keep oxygen for use in an emergency as there was no requirement to do so. However, guidance available from the National Resuscitation Council emphasises the use of oxygen to enable staff to respond to certain emergency situations.

There were systems in place to check the emergency equipment and medicines to ensure they were present, in date and in good working order. The nurse practitioner told us that they undertook these checks twice weekly. We looked at the records between April and August 2014 and saw that there was no clear pattern as to how frequently these checks had taken place (the checks varied from once a month to twice per week). The records had not specified what was being checked. We asked if the defibrillator was included in the checks and the nurse assured us that it was. The checks were not sufficiently robust and detailed to allow another member of staff to continue them in the nurse practitioner's absence. The nurse practitioner told us that there were no alternative arrangements in place to ensure the checks were carried out if they were absent.

Medicines management

The practice held some medicines on site such as emergency drugs and vaccines. We saw that medicines were stored securely and in the sample we checked the medicines were all in date.

Some medicines and vaccines need to be stored in the fridge at specific temperatures to maintain their quality and effectiveness. We saw that vaccines held at the practice were appropriately stored in the medicines fridge. We looked at records from May to August 2014 which showed that the fridge temperatures had been monitored. This was usually done daily but we found occasional gaps in the recording which could result in temperatures outside the manufacturer's recommendations going unnoticed.

The nurse practitioner was aware of the action to take if fridge temperatures fell outside the range needed for the storage of vaccines. They told us that they had in the past experienced problems with a medicines fridge which had since been replaced. In that situation they had needed to remove the vaccines from use. This provided assurance that staff would take appropriate action if there were concerns about vaccines in stock.

Although we were told that oxygen was not kept for emergency use we saw two oxygen cylinders in the practice. One cylinder had passed its expiry date and the other cylinder had no date recorded. We were advised that these cylinders were still in the practice because they were not sure how to dispose of them. We advised the GP that the unused and unmaintained oxygen cylinders must to be removed due to the fire risks associated with them particularly when stored in unventilated areas.

We spoke with the GP about how prescription pads were managed by the service. Prescription pads are controlled stationery because stolen prescriptions may be used to unlawfully obtain medicines. The GP advised us that prescription pads were signed in and out with the practice manager. We saw the book used to record this but no entries had been made. We asked if there was another book and staff believed that this may have been with the

Are services safe?

practice manager who was on leave at the time of the inspection. This did not provide adequate assurance that systems were consistently being followed to ensure the prescriptions could be accounted for.

There were systems in place for issuing repeat prescriptions so that patients on long term medication could be kept under review. This enabled the GP to check that the medicines prescribed to individual patients remained appropriate. Staff told us that the GP identified how many repeat prescriptions could be issued before the patient needed to be seen for a review. When the number of prescriptions issued had been reached a note was made with the prescription for the patient to make an appointment. We spoke with some patients who were on repeat prescriptions and they confirmed that they received regular reviews of their medicines.

Cleanliness and infection control

During our inspection we found the practice was clean and tidy. Staff had access to personal protective equipment such as gloves and aprons. Wipes were readily available for cleaning equipment between use. Disposable curtains were in place in the consulting rooms and staff advised us that they were replaced every six months. We saw dates recorded on the curtains to indicate when they were last changed and found this had been within the six months specified. There was a named infection control lead for the practice. We saw evidence that they had received training in infection prevention and control during the last year. These practices helped to minimise the risk of cross infection.

We saw that an infection control audit had been carried out in April 2014. However, there was no evidence available to show what actions had been taken in response to issues identified in the audit. We also identified some areas for improvement in relation to infection control as part of this inspection. For example, staff immunisation records were not available for all staff so we were unable to confirm that their immunisation status was up to date.

We saw a sharps bin for the disposal of contaminated clinical waste such as needles that had not be marked to indicate when it had been opened. There was no reference in the infection control policy that indicated how long sharps boxes should be kept once opened before being changed. We saw blood pressure cuffs and tourniquets in use in the nurse's room. These were of material that could not be wiped and no specific cleaning or replacement policy for these was in place. The health care assistant identified issues in patients using the non clinical waste bin to dispose of contaminated cotton wool following blood samples taken. There was no Legionella risk assessment or evidence that water systems had been tested. We found a Legionella risk assessment that had not been completed. There are legal regulations in place in the UK that cover the area of legionella control and water systems, and they are enforced by the Health and Safety Executive (HSE). Any organisation with public access to their water system has a duty of care to ensure there is a risk assessment in place to ensure legionella does not become a danger to health. The practice had not provided adequate assurance that infection prevention and control practices were adequately monitored in order to identify and improve practices.

Staffing and recruitment

Recruitment processes in place helped to ensure that staff employed to work at the practice had appropriate skills and experience and were of good character. We saw that there had been one new member of staff recruited within the last year. We saw that they had undergone a formal recruitment process which included the submission of an application form and interview. A disclosure and barring service (DBS) check and references had been sought to ensure they were suitable to work with vulnerable people. We saw that while the DBS check was awaited a risk assessment had been carried out to ensure patients were not put at risk from potentially unsuitable staff. Once employed we saw that they had been given induction training and regular supervision. We spoke with the member of staff who confirmed that they had received an induction when they first started in their role. However, their induction checklist had not been fully completed to demonstrate that their induction had been completed.

Although we received no major concerns from patients in relation to appointments and waiting times we saw that the main GP worked long hours to maintain the patient list. In addition the GP took sole responsibility for managing all patient related correspondence. The GP advised us that they gave a verbal handover of patients and duties when using a locum to cover leave. This highlighted a potential risk to the service in the event of an unforeseen absence.

The nurse practitioner had also developed a wide skill base. An unexpected absence of the nurse practitioner could also place a considerable burden on the practice in the absence of any succession planning.

Are services safe?

Dealing with Emergencies

Staff were not adequately equipped to manage situations which could affect the smooth running of the service, such as a power failure or staffing absences such as those due to illness. Staff confirmed there was guidance in place for business continuity and that the practice manager dealt with this. At the time of our inspection the practice manager was on leave and it was not evident that staff knew what to do in their absence if an emergency arose. We were unable to find a copy of the business continuity policy on the day of our visit and the business manager forwarded it to us the following day. We saw that the policy made reference to organisations that no longer existed and had no up to date list of contacts that staff might have needed. Areas of the policy had not been completed such as who the buddy practice was, although the GP advised us of this following our inspection.

Equipment

Equipment seen at the practice looked in good condition. We saw evidence of portable appliance testing of electrical equipment at the practice for checking electrical safety of equipment. Staff told us that calibration was also undertaken on equipment that required it.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment in line with standards

Patients we spoke with were happy with the service they received. Where appropriate, patients told us they had been referred to other health services for specialist care and treatment with no difficulties.

We asked clinical members of staff how they ensured that best practice was implemented. The GP advised us that they did this through continuing professional development and maintaining their skills. The GP told us that they worked sessions at a local hospice which enabled them to develop and maintain skills in end of life care. We saw from training certificates seen that the nurse practitioner regularly undertook training to update and expand their skills and knowledge.

The practice held gold standard framework meetings with district nurses and specialist nurses in cancer and palliative care. The gold standard framework is a national scheme aimed at improving the quality and care of patients at the end of their life. Staff told us that meetings were held every three months to help ensure patients received co-ordinated care. We saw minutes from these meetings relating to 2013 but no meeting minutes had been available for 2014. Staff assured us that there had been meetings held in 2014.

Patient registers were maintained for patients with long term conditions, so that their condition could be kept under review. Reception staff told us that they were involved in contacting patients to invite them to attend the practice for their review. We spoke with patients who had long term health conditions. These patients confirmed that they received regular reviews of their condition at the practice and told us that they felt well looked after.

We spoke with the GP about how they managed patients in a mental health crisis. The GP advised us that they had good support from the mental health team and would refer patients to the mental health team for an assessment if they had any concerns.

During our inspection we could not ascertain whether best practice had been implemented when caring and treating patients that may lack the capacity to consent. There was no reference within the practice's consent policy to the Mental Capacity Act 2005. This legislation governs decision making on behalf of adults when they do not have the mental capacity at a point in their lives for making specific decisions. None of the clinical staff had received training in the Mental Capacity Act 2005. Staff were unable to provide evidence as to how the Act had been implemented and how they had ensured that decisions made on behalf of a patient that lacked capacity were in their best interest. We spoke with managers at two care homes where the practice provided care for their residents including those with dementia. Neither of the managers expressed any concerns in the way in which the practice managed patients with dementia.

There were a range of policies in place to support staff in their work and staff knew where to find them if needed. However, none of the policies were dated or had a review date recorded so staff could not be assured they were following the most up to date policies.

Management, monitoring and improving outcomes for people

The practice was able to show examples of completed clinical audit cycles. Clinical audits enable the practice to monitor and identify areas in which it can improve outcomes for patients. We saw examples of two medicines audits that had been completed. In both examples the GP was able to demonstrate through re-audit improvements in prescribing in line with recommendations from the clinical commissioning group. We saw that an end of life audit had been carried out earlier in the year although this had yet to be re-audited to complete the cycle.

Effective staffing, equipment and facilities

Staff who worked at the practice were appropriately qualified to carry out their roles. We saw that where appropriate, staff at the practice were registered with their relevant professional body. This demonstrated that they had the right to practice in their professional capacity. The clinical staff we spoke with were able to demonstrate that they had undertaken continuing professional development during the last year. We saw various training certificates which showed that clinical staff were keeping their skills and knowledge up to date. We saw evidence that the GP was working towards revalidation, the mechanism by which doctors demonstrate their fitness to practice. However, the practice had not maintained a clear overview

Are services effective?

(for example, treatment is effective)

of what training staff had received. This made it difficult for the practice to determine whether staff were up to date with their own mandatory training and the skill base of the staff.

Not all staff had received regular opportunities to discuss their performance and learning needs through regular supervision and appraisals. From the staff records we noticed that the nurse practitioner had not received an appraisal since 2012, or any supervision in which they could discuss any concerns or issues relating to their work on a routine basis.

Working with other services

We saw evidence of joint working and information sharing with other services. Staff told us that meetings were held with health visitors. We saw evidence of this recorded in the staff meeting minutes where the health visitors shared information about their case loads with the practice.

Reception staff told us that patient information was received daily from other health providers such as information about patients seen in the out-of-hours period, hospital discharge letters and results from medical tests. These were passed to the GP who told us that they would review and act on information received on a daily basis. We asked the GP who managed this information when they were absent. The GP advised us that the practice manager would look at the information to see what needed to be acted upon and discuss this with the GP on duty.

The GP told us that they shared information with the out-of-hours provider usually by telephone or using a form to notify them of any patients that may be likely to access the service. The GP was unable to provide any examples where this had happened.

Health, promotion and prevention

Patients new to the service received a new patient check-up. These were carried about by the health care assistant and helped to identify any existing or new health issues so that they could be addressed. We spoke with patients that had recently joined the practice who confirmed they had received a new patient check-up.

The practice offered a range of health reviews for the management of health conditions such as diabetes and asthma. We spoke with the nurse practitioner who told us that they used these reviews as an opportunity to incorporate health promotion and education with the patient.

Disease prevention was also part of the nurse practitioner's role and clinics such as cervical screening, vaccinations and immunisations and smoking cessation were also run from the practice.

We found a wide range of health information available in the waiting area for patients to take away with them, including information about health screening programmes and various health conditions. This enabled patients to find out more about services available to them and their health conditions. Some information was also available in languages other than English. There were posters displayed on the noticeboard which included some local events, although some of these were now out of date. One member of the patient participation group told us that they had requested information about specific conditions and that the practice had responded to this request.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Results from the national patient survey January to September 2013 showed that patients were mostly satisfied with the service they received however results were worse than expected in being given enough time with the GP and in being able to make an appointment. The practice had also undertaken their own patient survey of 150 patients which indicated that these were not a concern. A system had also been introduced where patients who were willing to wait could walk in and be seen without making a former appointment.

Patients who used the service were treated with dignity and respect. During our inspection we observed that staff interacted with patients in a polite and respectful manner. Feedback received from patients about the staff was very positive. Staff were described by patients as polite, helpful and caring. We received feedback from two care homes where care was provided. One of the managers described the GP as the most sympathetic and kind doctor they had ever met.

Clinical staff were familiar with the steps they needed to take to protect patients' dignity when undergoing physical examinations. They told us about the ways they ensured patients were put at ease during an examination. A chaperone was offered to patients who wanted one. A chaperone acts as support and

accompanies the patient during a medical examination. Information about this was displayed in the waiting room so that patients were aware of the facility. Staff told us that both the nurse and some reception staff were used as a chaperone at the practice. They told us how they tried to support patients' cultural needs. For example, an Asian member of staff would usually chaperone for an Asian patient. We spoke with one of the reception staff who acted as a chaperone. They advised us that they had received training from the nurse practitioner to undertake this duty. The practice also employed a female GP in order to meet patient preferences when consulting on their health issues.

Staff were sensitive to patient confidentiality. We observed reception staff speaking in soft tones to patients. Receptionists told us that they would use a separate room away from the waiting area when a patient wanted to speak in private.

The waiting area was pleasant and spacious. Patients had access to a variety of health information, a television and water to aid their comfort in the waiting area while waiting for their appointment at the practice.

The practice provided support for patients who were at the end of their life, and their carers. The main GP worked sessions at a local hospice and was sensitive to the needs of patients at the end of their life and their families. We spoke to the manager at one nursing home who told us that the GP was very sensitive to the needs of family and carers, and would take the time to talk with them. The GP advised us that if patients wanted information relating to bereavement counselling services the reception staff would help them. Reception staff told us they would search for information about local services and groups when requested.

Involvement in decisions and consent

Patients we spoke with told us that they felt involved in decisions about their health care and treatment, and that information was given to them in a way they could understand. The practice used the 'choose and book' referral system which enabled them to give patients a choice of hospitals where they could be seen.

We spoke with the GP about how they obtained consent for treatment given to patients at the practice. The GP advised us that they would obtain and record verbal consent from patients when undertaking procedures such as joint injections. We were shown examples of consent recorded on records.

The practice had a consent policy in place which provided guidance to staff when they gave care and treatment to patients. The consent policy made reference to the Gillick competency for assessing whether children under 16 were mature enough to make decisions without parental consent. This allowed professionals to demonstrate that they had checked a person's understanding of proposed treatment, and used a recognised tool to record the decision making process. The GP told us that they did not currently have any specific examples where they had needed to apply the Gillick competency.

The practice was not able to demonstrate how best interest decisions were made where patients may not have the capacity to consent. They explained that they contributed to the best interest decisions made at the care homes in which they provided care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an understanding of the needs of the population it served. A breakdown of the practice population showed the main ethnic groups included white and black African / Caribbean people. The practice had provided a walk in blood pressure check service in response to the increased risk of high blood pressure among the black African / Caribbean population.

Patients in vulnerable circumstances were supported by the practice. The practice had a register for patients with learning disabilities. We looked at the records for two patients on this register and saw that they had received an annual health review. The practice also provided services to support patients who misused drugs and alcohol. Although there were currently no homeless patients on the practice list reception staff told us that they could register a homeless patient using the surgery address so that they could receive health care.

The practice was accessible to patients with physical or mobility difficulties. The entrance to the practice was via a ramp. The waiting room and corridors provided space for people who used a wheelchair or walking aid to access the practice easily and consulting rooms were situated on the ground floor. There was also a low reception desk so that patients who used a wheel chair could easily speak with reception staff. There were also toilet facilities available for people with mobility issues. We saw one patient who used a walking aid accessing the practice without any difficulty.

Home visits were undertaken where people had difficulty getting into the practice. This included carrying out weekly ward rounds at two care homes in the local area.

The practice supported people whose first language was not English to receive the health care they needed. Some of the staff (clinical and administrative) were able to speak more than one language but told us they sometimes used interpreters to assist with consultations. We saw several bookings that had been made with a translation service for the following week. Some of the patient information and leaflets displayed in the practice were available in languages other than English.

Access to the service

Information about the practice and the services available were advertised on the practice website, practice leaflet and on a notice board outside of the building. Practice opening hours and who to contact for health care when the surgery was closed was also available. This information helped patients to access services they needed. However the practice leaflet was in need of review to ensure information contained within it was up to date.

Staff at the practice told us that patients were able to access the service either by telephone, on-line via the practice website or by walking in. Some appointments were held for urgent appointments on the day. Staff told us that children under five and the elderly would be prioritised. The GP explained that they had recently introduced a walk in system where patients who were prepared to wait until the end of surgery would be seen. This had been introduced in response to feedback from patients. Feedback received on the day of our inspection indicated that most patients were satisfied with the current appointment system and were confident that they would be seen if their health concerns were urgent.

Meeting people's needs

Patients requiring specialist care or support were referred by the GP as required. Some patients we spoke with had undergone referrals to other health services and were satisfied with the way in which their referral had been made. We also spoke with the managers at two care homes supported by the practice. One manager told us that the GP would always refer patients promptly to other health services if needed.

Patients received appropriate support from the practice following discharge from hospital. Information received about patients such as hospital discharge information was usually received electronically or the patient would make an appointment to be seen. The GP told us that they would review this information on a daily basis so that any changes in the patients care or treatment could be promptly acted upon.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints within the practice. Staff told us that the practice manager was responsible for the management of complaints received about the practice. We asked one receptionist what they would do if someone wanted to make a complaint. They provided us with a

Are services responsive to people's needs?

(for example, to feedback?)

'complaints and comments' form that patients could complete. The form clearly provided information to patients as to who they should contact at the practice with their complaint. It also provided details of external organisations the patient could contact if they were not satisfied with the way in which the practice managed their complaint or if they had not wished to complain directly to the practice.

We saw that there had been four complaints received in the last year and an annual review of the complaints received had been carried out. We saw from the response letters that complaints had been fully responded to. Staff told us that they would be made aware of any complaints made about them. However. we spoke with one person who was not happy with the way in which their complaint was managed. They told us that they had spoken with the practice manager but had not received any feedback. The staff told us that they did not have any systems in place for recording verbal complaints.

Information about the complaints process was not clearly available to patients. We did not see any information displayed in the patient areas on how to make a formal complaint. This could prevent some patients from raising their concerns with the practice and having them addressed.

The practice had a patient reference group (PRG) for discussing issues that affected patients. The PRG is a way in which patients and GP practices can work together to improve the quality of the service provided. The group had met on two occasions to date. The two members of the PRG we spoke with expressed their general satisfaction with the service.

Are services well-led?

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

Our findings

Leadership and culture

As a sole provider the GP was the clear lead for the practice supported by the practice manager. The GP had a vision for the future of the practice which involved extending the level of services provided, although there was no formal written plan for this.

We found that the GP worked long hours to meet the patient's clinical needs and maintained responsibility for many aspects of the service. This raised a potential risk should the GP need to take periods of absence. There was also little time available for the GP to oversee the management, performance and quality monitoring aspects of the service provided.

On a day to day basis staff told us that they felt supported and that senior staff were approachable if they needed to raise any issues. Staff told us that they worked well as a team. Some staff felt supported in relation to personal development but this was not consistent across all staff. There was also an absence of regular supervision sessions for some staff to discuss their training needs and the support they required to continue to meet the needs of the practice.

Governance arrangements

Governance arrangements were not sufficiently robust to effectively monitor service provision and identify the risks to the health, welfare and safety of service users. Monitoring of service provision was not always a systematic process and completed in sufficient detail so as to identify areas for improvement and mitigate against future risks. For example monitoring of fire safety and infection control practices. Business continuity plans were not sufficiently robust to ensure the continuation of the service in the event of an emergency.

Staff meetings were the main forum through which issues relating to the practice were discussed and disseminated among staff. The meetings were held approximately four times each year and were open to all members of staff. However, attendance was not recorded so it was not clear that information had been consistently shared. The minutes of the meetings were recorded as bullet points and were not an easy source of reference for staff. The minutes did not clearly identify actions which needed to be taken and followed up.

Systems to monitor and improve quality and improvement

The practice participated in the quality outcomes framework (QOF). This is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients. The GP advised us that they employed a QOF administrator who managed the patient data and identified patients into the practice when they needed to be seen. The QOF administrator was not available to speak with us on the day of the inspection.

We asked the GP about some of the national performance data available, such as the national patient survey and General Practice High level Indicators. We asked how the practice used this data to identify areas for improvement. The GP told us that these were not specifically discussed but was not aware of any major concerns with their performance.

Patient experience and involvement

The practice sought the views of patients through their patient reference group (PRG). The PRG is a way in which patients and GP practices can work together to improve the quality of the service provided. We saw that the practice had tried to ensure that the group represented the population served. A breakdown of members by age and ethnicity had been produced which demonstrated that there was a diverse membership within the group.

The practice had also undertaken a patient survey within the last 12 months with input from members of the PRG in the design of the survey. Feedback about the quality of the service was received from 150 patients and was very positive.

Practice seeks and acts on feedback from users, public and staff

Staff described the practice as having an open culture. We saw that there was a whistleblowing policy in place. Whistleblowing is the process by which staff can raise concerns they may have about the practice and the conduct of other members of staff. This enables concerns raised to be investigated and acted on to help safeguard patients from potentially unsafe or inappropriate care. Although the policy described the internal process for reporting concerns it did not include what staff should do if they felt they could not raise concerns with senior members of staff.

Are services well-led?

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

We saw from the PRG report that there had been two PRG meetings to date; the latest meeting was held in March 2014. Issues discussed included appointments and the internal patient survey. Although attendance had not been recorded, members of the patient group advised us that staff including the GP and practice manager had attended the meetings. This ensured that staff that could influence change were there to listen to the patients views. The members of the PRG we spoke with told us that they had felt listened to. They told us that changes had been made as a result of comments made such as the introduction of online booking for appointments and the availability of patient information.

Management lead through learning and improvement

Opportunities for learning and improvement were limited to the practice meetings. These provided the main forum for discussions about performance issues affecting the practice. However, there was no set agenda for the meetings to ensure that performance and other key issues were continuously monitored.

Identification and management of risk

Risks relating to the management of the practice had not been clearly identified and addressed. We found some evidence of audits had been carried out to identify potential risks to the service, but these did not clearly show what action had been taken to address issues that had been identified.

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.

Our findings

Staff at the practice told us that they guaranteed appointments for older patients on the same day. Home visits were provided for those that were too ill or infirm to attend the practice. This enabled patients that were more vulnerable to worsening health conditions to be seen quickly. We saw vaccinations advertised for patients over 70 years of age.

The practice looked after patients that lived in two nursing homes for older people. The main GP undertook ward rounds each week at both these homes. We spoke with managers at these two homes and both were satisfied with the level and support they received from the practice. One was a 90 bedded care home which included older people with dementia. The GP visited this home twice a week. They described the GP as sympathetic and kind and that they listened to what the home had to say and dealt with any concerns promptly. The manager told us that the GP had given them their personal mobile if they needed to contact them quickly. A manager from the other home told us that they were satisfied but there had been occasions when the GP had not been able to come out.

As part of the GP contract patients over 75 years old should have a named GP accountable for their care. As the service was provided by a sole provider the GP explained it was them and that continuity of care for patients was not an issue at the practice.

The GP told us that they had recently signed up to provide an enhanced service to help reduce the number of emergency admissions of patients to hospital. Progress to date had been around identifying patients who were at risk of emergency admissions.

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).

Our findings

Some of the patients we spoke with as part of our inspection told us that they had long term conditions. They told us that they felt looked after by the practice and that their condition was kept under review. The practice advertised in the practice specific services for the management of patients with diabetes, hypertension and asthma so that patients with these conditions knew they were available.

The practice participated in the quality outcomes framework (QOF). A voluntary incentive scheme for GP practices which rewards them for how well they care for patients. Included in QOF are reviews of patients with long term conditions. The practice maintained various registers for patients with long term conditions and undertook health reviews of patients on these registers. This enabled any deterioration or issues relating to their condition to be identified promptly and managed as appropriate.

The nurse practitioner who undertook some of the health reviews told us about some of the training they were undertaking in order to keep their knowledge up to date and support patients with long term conditions, such as courses in spirometry (tests that help identify and monitor lung conditions).

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

Staff at the practice told us that children under five years old would always be seen even when appointments were full.

The practice worked with both the midwifery team and health visitors in the provision of care to mothers and young children. The GP advised us that if there were any concerns about this group of patients the midwife or health visitor would contact them. We saw evidence from the practice minutes that information had been shared with health visitors. This helped to provide a continuity of care.

We saw from the practice leaflet that child health and immunisation services were provided at the practice. The GP told us that they undertook the six week baby checks. However, there were no specific processes in place to follow up children who did not turn up for their appointments.

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.

Our findings

The practice offered appointments from 8am twice each week and up to 7.30pm one evening each week. This enabled patients, who were unable to attend during the day due to work and other commitments, to make more convenient appointments.

Patients new to the practice and patients over the age of 40, including those with no known health concerns, were offered the NHS health check. Cervical screening was also available to detect early signs of cervical cancer. This helped identify and manage potential health risks to patients at the earliest possible stage.

The nurse practitioner provided services to support patients with healthier life styles such as smoking cessation and weight management. We saw that there was a range of health information available at the practice for patients to take away to help them understand more about their health conditions and services available to them.

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).

Our findings

Patients in vulnerable circumstances were supported at the practice. The practice had a register for patients with learning disabilities. We looked at the records for two of the 12 patients on this register and saw that they had received an annual health review. The practice also provided services to support patients who misused drugs and alcohol. Although there were currently no homeless patients on the practice list reception staff told us that they could register a homeless patient and use the surgery address so that they could receive health care.

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.

Our findings

The GP described good working relationships with the local mental health trust. They told us that patients in mental health crisis were referred to the mental health team for assessment. The practice provided support for patients in relation to drug misuse. As part of its enhanced service provision a controlled drugs worker was contracted by the practice to help support and manage patients with drug addictions. The practice also provided antipsychotic injections to help manage mental health conditions for patients in the community.

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 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 Governance arrangements were not sufficiently robust to effectively identify the risks to the health, welfare and safety of service users. Monitoring of service provision was not always a systematic process and completed in sufficient detail so as to identify areas for learning or action. Risks to the service and how they were mitigated against had not been clearly identified by the practice. Regulation 10 (1) (a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Systems in place for managing the risks to patients and others relating to fire safety and legionella were not robust. Out of date oxygen tanks were held in the practice which require immediate removal. Regulation 15 (1) (a) (c)