Dr B Fernando & Dr K Manivannan

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr B Fernando and Dr K Manivannan on 9 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, people whose circumstances may make them vulnerable. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to emergency situations.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Data showed patient outcomes were average for the locality. Audits had been carried out, we saw evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments.

The areas where the provider must make improvements are:

Summary of findings

- Ensure risk assessments and required equipment is in place for dealing with medical emergencies.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their roles and responsibilities to respond to medical emergencies. However, the practice was unable to demonstrate they were fully equipped to deal with medical emergencies as no medical oxygen was available. The practice provided safe and suitable care that protected patients from avoidable harm and abuse. Staff were aware of the policies and procedures for reporting concerns and safeguarding of vulnerable adults and children. Staff had received training in safeguarding children and vulnerable adults. The practice had undertaken an analysis of significant events in the last 12 months where learning points and actions had been recorded. Medicines kept on the premises were stored appropriately and securely. Staff were aware of emergency procedures and knew where the resuscitation equipment was kept.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice had systems to help ensure they could effectively respond to the needs of their patients. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. Information regarding the care received by patients was shared with other healthcare professionals in a timely manner to help ensure continuity of care. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to comprehend. Staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. There were mechanisms to respond and take action when things did not go as well as expected. There was a complaints process and responses were made in a timely manner. Patients were given the opportunity to make suggestions to improve the services provided, were listened to and actions had been taken to make changes where practicable to do so.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

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

Good

The provider was rated as good for the care of older people. The practice identified older patients and their carers who may have needed on-going support. The practice provided home visits for those who were housebound or too ill to visit the surgery. There were district nurses and community nurses who worked closely with the practice and were available to give nursing care to older patients in their homes. The practice offered influenza and pneumonia vaccinations for patients over 65 years of age. Patients 75 years of age or over had a named GP and the practice's nurses made regular visits to patients at a local care home for older people.

People with long term conditions

Good

The provider was rated as good for the care of people with long term conditions. The practice nurses treated patients affected by minor illnesses and monitored their chronic diseases. For example, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and heart disease. The practice provided diabetic, weight management and asthma clinics that were run by the nurses in conjunction with the GPs. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. There were emergency processes and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The provider was rated as good for the care of families, children and young people. Immunisation rates were relatively high for all standard childhood immunisations compared with the national average. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered child health checks and antenatal clinics. A full range of family planning services were offered by the practice.

Working age people (including those recently retired and students)

Good

The provider was rated as good for the care of working age people (including those recently retired and students). The needs of the working age patient population, those recently retired and students

Summary of findings

had been identified and the practice had adjusted the services it offered to help ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered extended hours. The practice was open from 8.30am until 6.30pm Monday to Friday with a late evening on Monday and Wednesday from 6.30am until 7.30pm**.** This was primarily for patients who found it difficult to attend during working hours.

People whose circumstances may make them vulnerable

Good

The provider was rated as good for the care of people whose circumstances may make them vulnerable. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The provider was rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice kept a register of all patients with a learning disability who were offered an annual physical health check. Patients identified with mental health problems were managed well.

Patients and those close to them were offered emotional support from suitably trained staff if they needed it. The practice also kept an up to date list of telephone numbers for counselling services and the mental health crisis team. The practice had posters in the waiting area signposting patients to information on dementia and counselling.

Patients were able to self-refer for bereavement counselling to the local hospice and any patients with depression who needed help were given a contact number to self-refer to a counsellor. The practice also had links with counsellors who saw patients privately.

Summary of findings

What people who use the service say

During our inspection we spoke with eight patients. Patients were complimentary about the care they received and told us that the staff were helpful, knowledgeable and they felt safe and well cared for.

We looked at 28 completed comment cards. The majority of comments we received were positive. Some patients said they had used the practice for a long period of time and they were satisfied with their care. Patients said the staff always did their best and the premises were hygienic and safe.

The results from the National Patient Survey showed that 95% of patients said that their overall experience of the practice was good or very good and that 88% of patients would recommend the practice to someone new to the area.

The practice sought feedback from staff and patients, which it acted on. The practice had a patient participation group (PPG) who they worked with to address concerns from patients. The last practice patient survey in December 2013 demonstrated that most respondents were satisfied with the practice overall.

Areas for improvement

Action the service MUST take to improve

Ensure risk assessments and required equipment is in place for dealing with medical emergencies.

Dr B Fernando & Dr K Manivannan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor.

Background to Dr B Fernando & Dr K Manivannan

Dr B Fernando and Dr K Manivannan (also known as Thames Avenue) are situated in a converted house and located in the residential area of Rainham Kent. Wheelchair access to the building is through the front door. The practice serves an area that is the second least deprived in comparison to the England average.

A team of one full time partner, one part-time partner (both male), four female nurses, two female healthcare assistants, four part-time receptionists, a practice manager, information manager and secretary provide care and treatment for approximately 4,836 patients (the practice had acquired nearly 700 patients from a neighbouring practice). There is a vacancy for one full time salaried GP and used a locum GP for consistency. The practice is not a training practice.

Practice nurses are qualified and registered nurses. They can help with health issues such as family planning, healthy living advice and blood pressure checks. The practice nurses run clinics for long-term health conditions such as asthma or diabetes, minor ailment clinics and carry out cervical smears. Healthcare assistants support the practice nurses with their daily work and carry out tasks such as phlebotomy, blood pressure measurement and new patient checks. They may act as a chaperone when a patient or doctor requests one.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 December 2014. During our visit we spoke with two GPs, the practice manager, practice nurse manager, one practice nurses, two healthcare assistants, four receptionists, the information manager and eight patients who used the service. We reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term. The practice used a range of information to identify risks and improve quality in relation to patient safety, for example, reported incidents, national patient safety alerts as well as comments received from patients. The practice had developed systems to respond to identified risks. For example, staff we spoke with described the procedure for dealing with safety alerts from outside agencies to keep the practice up-to-date with failures in equipment, processes, procedures and substances.

Staff we spoke with were able to describe their responsibilities in relation to monitoring, reporting and recording incidents and concerns. They told us they knew the reporting procedures within the practice and were aware of the external authorities that may need to be notified if appropriate.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. The practice also had a serious incident policy. We discussed significant event reporting with the practice manager. They told us staff completed a form and discussed the incident with them. The incident was then discussed at partnership and staff meetings. Minutes of clinical governance meetings demonstrated discussions of significant events were a regular item on the agenda, and subsequent learning points and actions had been taken and recorded. For example, we were told that a patient who had a change in their condition following a prescribed medication, the practice reviewed its procedures and consulted with other professionals which resulted in the medication being withdrawn.

Reliable safety systems and processes including safeguarding

A named practice nurse was identified as the safeguarding lead. The GPs and nurses had all received safeguarding training for children to level three and further training for vulnerable adults to help them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

The practice had policies and procedures for safeguarding vulnerable adults and children which included contact details of the local safeguarding teams. The policy described the different types of abuse. There were flow charts and contact numbers for named nurses and GPs who led on child protection, as well as police, social services and local authority designated officers.

All patients over the age of 75 years had a named GP. The practice had a chaperone policy. The practice considered that this was a formal role and only nurses or healthcare assistants were allowed to undertake this role and had received the relevant training.

The practice had a Disclosure and Barring Service (DBS) policy that stated it was essential for all clinical staff to have a criminal records check to help ensure that people who used the service were protected. There was a risk assessment for non-clinical staff to cover those who may come into contact with patients both with others present and when they were on their own whilst working at the practice.

Medicines management

The practice stored vaccines and had medicines for emergency situations. The practice followed guidelines for maintaining the vaccine cold chain so that the viability of vaccinations was assured. Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There were processes for checking that all medicines and vaccines were accounted for. Temperature checks for the refrigerators used to store medicines had been carried out and all medicines and vaccines were stored at the correct temperature. There were processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice did not hold stocks of controlled medicines (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Requires improvement

Are services safe?

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

Records of practice meetings noted the actions taken in response to a review of prescribing data. For example, patterns of long acting insulin (used in diabetes) prescribing within the practice. We saw that after discussion the practice decided that patients were individuals and they needed to be put on a regime that suited them depending on their lifestyle.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Patients requiring repeat prescriptions were able to request them either on line, in writing or put the repeat prescription paper request in the post box in reception. The practice offered the electronic prescription service, which allowed patients to choose or "nominate" a chemist to collect their medicines or appliances from. In the interests of safety, the practice did not accept requests for repeat prescriptions over the telephone or by fax.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company. We saw evidence that the waste disposal company had carried out a clinical waste audit in January 2014 and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audit were discussed. We saw evidence that a cleaning audit had been undertaken and found that cobwebs were high behind window blinds. We saw that an infection control audit was undertaken on 25 November 2014 and showed that staff did not have links with external agencies for example the Health Protection Agency but felt that if there was an issue they would contact them. It also showed, that the practice did not have cleaning instructions for the ear syringe machine and spirometer (equipment used for measuring the volume of air inspired and expired by the lungs). We saw that written instructions were available for staff to follow.

The practice had an Infection Control policy that outlined the procedures for staff to follow to help ensure that the Code of Practice for the Prevention and Control of Health Care Associated Infections was implemented. The code sets out the standards and criteria to guide NHS organisations in planning and implementing infection control measures. A practice nurse was the designated lead for infection control.

We spoke with the lead for infection control who told us that they were planning to undertake a hand washing audit, however, there was no evidence available to support this.

Equipment

Nursing staff told us that they had adequate equipment to enable them to carry out diagnostic examinations and treatment. This included equipment and medicines to help ensure that staff were able to provide the appropriate assessment and treatment to patients. All portable electrical equipment was routinely tested in line with national guidance. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement

in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. For example, service contracts with specialist contractors in relation to fire safety and electrical testing.

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We looked at minutes of a monthly clinical meeting and saw that a discussion had been held about a significant event relating to the medicines management of a patient.

Arrangements to deal with emergencies and major incidents

The practice was open from 8.30am until 6.30pm Monday to Friday with a late evening on Monday and Wednesday from 6.30pm until 7.30pm**.** Patients who telephoned the practice when it was closed heard a recorded message that gave them information on how to access out of hours care and advice.

The practice did not have suitable arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. The practice did not have access to medical oxygen but did have an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Medical oxygen is considered essential in dealing with certain medical emergencies (such as acute exacerbation of asthma and other causes of hypoxemia). We asked the practice manager why the practice held limited emergency equipment and were told that they were not necessary as no medical emergencies had occurred and in the event of one happening an ambulance would be called as the response time was quick as the local hospital was a short distance away. However, the practice had not carried out any risk assessments to determine this arrangement would be safe or appropriate. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylactic shock and low blood sugar. Processes were also in place to check emergency medicines were within their expiry date and suitable for use and we saw that they were.

The practice had a business continuity plan. This included all essential elements including loss of site, loss of power, loss of the computer system , staffing and what to do and who to contact in each scenario. For example, contact details of who to contact in the event of power failure. However, there was no element to show how the practice would handle an adverse weather situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, ear nose and throat problems, childhood illnesses and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Practice nurses were qualified and registered nurses. They helped with health issues such as family planning, healthy living advice and blood pressure checks. The practice nurses ran clinics for long-term health conditions such as asthma or diabetes, minor ailment clinics and carried out cervical smears. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice was able to identify all appraisals and personal development plans for all staff.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us a clinical audit that had been undertaken in the last year. This audit was conducted in relation to blood pressure (BP) and body mass index (BMI) of patients who were on the combined contraceptive pill being taken every 12 months. An analysis showed that of the 142 patients who had been prescribed the combined contraceptive pill in the last 12 months, 16 patients had not had their BP recorded last 12 months and 11 patients had not had their BMI recorded last 12 months. Actions taken were that these patients would be recalled and their BP and BMI would be recorded and that nurses would check BP and BMI during pill check. The audit was to be undertaken again the following year.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. We saw an audit

Good

Are services effective?

(for example, treatment is effective)

that was conducted following a Medicines and Healthcare products Regulatory Agency (MHRA) update in relation to the cardiovascular risks of using a particular medicine. An analysis showed only five patients were taking this medicine and none of them were found to have any contraindications so did not need to stop taking it. The audit was disseminated among the GPs and nurses to make them aware of the issue. The practice were repeating this audit in 2015 again because they had acquired nearly 700 patients from a neighbouring practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients had achieved a score of 885.85 points out of a maximum of 900 equating to 98.4%. For example, 92% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) cancer and dementia. This practice was not an outlier for any QOF (or other national) clinical targets.

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

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in such areas as child immunisation, antibiotic prescribing and hospital referral rates.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one number having additional diplomas in sexual and reproductive medicine, and one with diplomas in children's health and obstetric. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the lead nurse had been supported to obtain a diploma in diabetes.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from

Good

Are services effective?

(for example, treatment is effective)

communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice staff communicated with the local hospital by telephone and gave letters containing necessary information to paramedics when patients were transferred to hospital one GP highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record Vision to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Nursing staff we spoke with told us that before any invasive procedure was undertaken, they informed the patient and gained their consent. Nursing staff told us they did not perform any procedure that patients' who lacked capacity did not understand. They told us that if they were concerned that a patient did not have capacity to understand proposed care or treatment, they discussed their concern with a GP. Nursing staff told us that in the case of a patient who lacked the capacity to consent, an advocate or carer was encouraged to accompany them for their appointment. Training records confirmed that staff had received training in the Mental Capacity Act 2005.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. There was a range of health promotion and information leaflets available in the practice and on the practice's website. A practice booklet was also available either in paper form or electronically from the practice's website. Information included details of cervical screening clinics, family planning clinics, child health and immunisation. The practice provided individual screening for chlamydia and sexual health advice for patients aged 15-24. Patients aged 25 and above were referred to the sexual health clinic at the local hospital.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. For example, for the triple vaccine against measles, mumps, and rubella (MMR) for two year old children the practice had achieved 100% compared to the CCG rate of 92.9%.

All registered patients aged 16-74 were invited to have a health check every three years and all patients over 75 to have an annual health check. All patients suffering from long-term health conditions such as diabetes, respiratory disease, heart disease/stroke and hypertension were invited to attend for an annual health review. Practice nurses provided support, monitoring and advice in conjunction with the GP. The nurses provided advice on the menopause and hormone replacement therapy (HRT), and cervical screening. Patients with asthma or who use an inhaler were invited to make an appointment with the specialist asthma nurse for a review.

All new patients were required to complete a new patient health questionnaire, ethnic origin form and were invited to make an appointment with a named healthcare assistant. This gave the practice an opportunity to meet the patient and obtain important information about any past and on-going health problems.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/2014, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 95% of practice respondents saying the GP was good at listening to them and 94% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. GPs we spoke with confirmed that chaperones were offered routinely and that this was recorded in the patient's notes.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Patients and those close to them were offered emotional support from suitably trained staff if they needed it. The practice kept an up to date list of telephone

Good

Are services caring?

numbers for counselling services and the mental health crisis team. The practice had posters in the waiting area signposting patients to information on dementia and counselling.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice had (PPG) who they worked with to address concerns from patients. The 2013-2014 patient survey, showed that a very high number of patients were happy with the service provided by the practice and the facilities. However, one particular question did receive a slightly negative response from some of the patients. "Please rate the ease of making an appointment to see the doctor". In collaboration with the PPG, the practice designed and published a leaflet for patients explaining the many reasons why they could not always offer a swift appointment and also the work that would be undertaking to improve the problem. For example, the practice manager was monitoring the appointment system to pinpoint high and low demands for appointments. The PPG had put lots of work into preparing and displaying relevant posters. Practice staff had also carried out some work with the other notice boards, making sure that posters were rotated regularly, giving patients a fresh view each time they visited. The practice was seeking an additional GP to join the team, but in the meantime had help from a regular locum GP, therefore, allowing patients' faster access to seeing a GP. Data from the national patient survey showed 88% of practice respondents described their experience of getting an appointment as good.

The practice had a "Friends and Family Test" questionnaire that could be accessed on line or in paper form. This gave patients the opportunity to say whether or not they would recommend the practice to friends and family if they needed similar care or treatment.

Tackling inequity and promoting equality

The practice told us it did not have specific groups of patients in vulnerable circumstances such as travellers, homeless people or asylum seekers. However, staff had access to interpreters via the internet and information in different languages. In addition, there was an agreed policy that the practice would use its own address for anyone that was homeless to help ensure they were able to receive appropriate care and support. There was access to a hearing loop for people who had hearing impairment and, if required, the practice contacted a local service for signing for patients with a hearing problem.

The practice was situated on the first and second floors of the building with all the services for patients on the first floors. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

The premises and services had been adapted to meet the needs of patient with disabilities. There was disabled parking spaces to the rear of the premises and wheelchair access to the building was through the front door. We saw that the corridors were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams, however, the door frames were narrow and did not allow for easy access. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open from 8.30am until 6.30pm Monday to Friday with a late evening on Monday and Wednesday from 6.30pm until 7.30pm**.** The practice's extended opening hours was particularly useful to patients with work commitments. The practice provided home visits for those who were housebound or too ill to visit the surgery. Patients requiring appointments were able to book and manage them on line.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes by a practice nurse.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

If patients were ill while away from home or if they were not registered with a doctor but needed to see one, they could receive emergency treatment from the practice for 14 days. After 14 days they needed to register as a temporary or permanent patient. They could be registered as a temporary patient for up to three months. This allowed them to be on the practice list and still remain a patient of their permanent GP. After three months they had to re-register as a temporary patient or permanently register with the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system for example, posters in the waiting area, in the practice leaflet and on the practice website. The practice had a complaints policy that adhered to NHS guidelines. It described the timescales for response, the time limits to complain, the designated person to deal with the complaint (practice manager), the right of appeal and further action patients could take if not satisfied through the complaints manager at NHS England Kent and Medway Team. The practice had reviewed complaints on an annual basis to detect themes or trends. In the last year the practice had received six complaints. Minutes of clinical meetings showed that the complaints log was circulated to all relevant staff and discussed, showing how the complaints were handled, lessons learnt and any action taken.

Patients were able to give feedback through complaints, verbally, via a suggestion box and on the NHS choices website. The practice had responded to comments on the NHS choices website. The practice had a complaint form advising patients how to complain, what to do for a complaint being made on behalf of someone else, what the practice would do regarding an initial response (three working days) and a resolution date (10 working days).

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice philosophy and strategy was to create a health care facility in 1994, providing personalised care and maintaining quality, efficiency and effectiveness. Their aim was to provide high quality care in a responsive, supportive, courteous manner, through the continuous professional development of their highly motivated team. They are committed to preserving and enhancing their good reputation as a caring and innovative practice. By respecting the dignity and diversity of the community they served, they strived to provide a service which put patient welfare at the heart of all they do. The practice's goal was to provide a relaxed and friendly environment where patients had the choice of healthcare professionals and appointment times.

We spoke with 12 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

There were different partners responsible for certain areas of management within the practice. For example, finance and business, Quality and Outcomes Framework (QOF) monitoring, data entry, complaints monitoring, governance, management and protocols.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 12 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 12 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and lead nurse for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Minutes of staff meetings demonstrated that risk was a topic on the rolling agenda. The practice had a well written and robust risk management policy which included the risk management matrices.

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

The practice did not have systems for risk assessments for emergency situations to identify where action should be taken.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We were sent additional audits after the inspection date which included audits of medications, for example Sotalol, (used for the treatment of a heart condition). We were sent an audit of patients who had been diagnosed with gout and the associated risk of cardio-vascular disease and saw that the actions taken were to invite the patients into the practice for screening and reminders sent to the GPs to remember to undertake a cardio vascular risk assessment in patients diagnosed with gout.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. We reviewed the following policies and protocols, disciplinary procedures, the induction policy and management of sickness which supported staff. A staff handbook was available to all staff, which included sections on equality as well as harassment and bullying at work.

There were weekly, alternate week, quarterly and annual meetings that included staff at all levels. When we spoke with staff they told us they could talk to anyone at any time and felt that they would be listened to.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG had carried out annual surveys and met every quarter. Analysis of the last patient survey was considered in conjunction

Are services well-led?

Good

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

with the PPG. The results and actions agreed from these surveys were available on the practice website. The practice had gathered feedback from patients through patient surveys and complaints received. Results of the annual patient survey resulted in the GP partners looking at the possibility of restructuring the appointment system to meet the needs of their ever changing patient population. We looked at mintues of the PPG meeting for 16 October 2014 and saw that a review of the current appointment system had been discussed. The results of this review and an action plan for improvements were to be shared with the CCG by 31 October 2014. We looked at the results of the annual patient survey and 95% of patients described their overall experience of this practice as good.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy that was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings and away days to help the practice improve outcomes for patients. For example, on reviewing one patient's medicines following an admission to hospital, the GP realised that the patient had been on long-term steroids (also known as cortisone or corticosteroids) that decrease inflammation. They noted that the patient had a history of osteoporosis (a condition that weakens bones, making them fragile and more likely to break). They saw that no specific medicines for osteoporosis had been prescribed. When analysing this case, the practice established that they had not prescribed medicines for bone protection for a patient with known osteoporosis. It was agreed that all patients on steroids would be reviewed to see whether they had been prescribed medicines for bone protection. The practice also reviewed its practice of removing old medicines from patient's prescriptions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services, in order to mitigate the risks arising from such emergencies to service users. Regulation 12 (1)(2)(a)(b)