Dr Chandrika Ramu

Quality Report

95 High Street
Milton Regis
Sittingbourne
Kent. ME10 2AR
Tel: 01795 426640
Website:

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Chandrika Ramu on 19 May 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe and well led services. The concerns which led to these ratings applied to all population groups. We therefore found that the practice required improvement for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), as well as people whose circumstances may make them vulnerable and people experiencing poor mental health (including dementia). We found the practice was good for providing effective, caring and responsive 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, although staff may not have been fully aware of the type of incident that should have been reported. Information about safety that was reported was recorded, appropriately reviewed and addressed.
- Data showed that many patient outcomes were above average for the locality and there was evidence that the Quality and Outcomes Framework (QOF) was used by the practice to monitor performance and drive improvement.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- Information about services and how to complain was available and easy to understand.
- The practice had a number of policies and procedures to govern activity and these had been reviewed and were in date.

Summary of findings

- The practice had not always undertaken audits to monitor quality and safety, including infection control, training, and completed clinical audits to help drive improvement.
- The practice identified and addressed risks to patients, although a risk management process had not been fully developed to assess and record all risks, including those relating to recruitment checks, some areas of infection control and medicines management.

There were areas of practice where the provider must make improvements. Importantly, the provider must:

- Ensure recruitment arrangements include all necessary employment checks for all staff, including appropriate checks for locum staff.
- Ensure the safe management of medicines, medical equipment and security of prescription forms.
- Ensure effective management of infection prevention and control.
- Ensure the practice governance arrangements include audits to monitor quality and safety, including completed clinical audit cycles.
- Ensure the practice governance arrangements include a system of risk assessment and management, including analysis of significant events and improved staff awareness of incidents that require reporting.

In addition the provider should:

- Review the training requirements for staff in keeping mandatory training updated.
- Review the arrangements for undertaking timely staff appraisals.

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 responsibilities to raise concerns, and to report incidents and near misses, although staff were not always clear about the type of incidents that were required to be reported. Incidents that had been reported were investigated and the lessons learned were shared to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not fully implemented to help ensure patients were kept safe. For example, there were concerns in relation to recruitment checks, infection control and medicines management.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and further training was planned. Staff worked with multi-disciplinary teams and other care professionals to support patients' needs.

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 for patients about the services available was easy to understand and accessible. We also saw that 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 clinical commissioning group (CCG) to review the services provided. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice had learned from complaints.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had set out the aims and objectives of the practice and staff were aware of their responsibilities in relation to these. Staff felt supported and knew who to approach with issues. The practice held regular meetings and sought feedback from staff and had mechanisms to receive comments and feedback from patients. However, the practice governance arrangements did not always include regular auditing to monitor quality and safety of the services and did not include a fully developed risk management process. Staff had not received performance reviews in the last year.

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

Requires improvement

The practice is rated as requires improvement for the care of older people because the concerns that we found regarding providing safe and well-led services applied to all the population groups. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older people in its patient population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions because the concerns that we found regarding providing safe and well-led services applied to all the population groups. Staff provided chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and there were annual reviews to check that their health and medication needs were being met.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people because the concerns that we found regarding providing safe and well-led services applied to all the population groups. There were systems to identify and follow-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Good examples of joint working with midwives and health visitors were observed.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students) because the concerns that we found regarding providing safe and well-led services applied to all the population groups. The needs of the working age population, those recently retired and students had

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been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable because the concerns that we found regarding providing safe and well-led services applied to all the population groups. The practice held a register of patients living in vulnerable circumstances including those with a learning disability, who had received annual health checks. The practice also offered longer appointments for people with a learning disability.

The practice worked with multi-disciplinary teams in the case management of vulnerable people and there was information 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)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia) because the concerns that we found regarding providing safe and well-led services applied to all the population groups. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. There were care plans in place for these patients.

The practice provided information for patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection. All the patients we spoke with were positive about the services they received from the practice and said they felt the care and treatment was good. Patients told us they had no concerns about the cleanliness of the practice and that they always felt safe. Patients said referrals to other services for consultations and tests had always been efficient and prompt.

Patients were particularly complimentary about the staff, and said they were always caring, helpful and efficient, and that they were treated with respect and dignity.

Patients told us the appointments system worked well and they were able to get same day appointments if urgent. All patients told us they always had enough time with the GPs and nurses to discuss their care and treatment thoroughly, they never felt rushed and that they felt involved in decisions about their care.

We reviewed 47 comment cards completed by patients prior to our inspection. The majority of comments were very positive and expressed satisfaction about appointments, the staff and being treated with care and consideration. They included comments in relation to having enough time with the GPs and nurses, as well as being involved in discussions and decisions regarding their care and treatment.

Information from the 2014 national patient survey showed that the practice had been rated well in many areas, compared to other local practices. For example, 80% of respondents said that the last time they saw or spoke with the GP they were good or very good at treating them with care and concern, compared to the local average of 76%. Similarly, 98% of respondents said the last appointment they got was convenient, compared to 90% locally. The practice was also rated well in many areas when compared to the national averages. For example, 97% of respondents said they found it easy to get through to the practice on the phone, compared to 72% nationally. Also, 95% of respondents said that they were satisfied with the practice opening hours, compared to 76% nationally.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff, including appropriate checks for locum staff.
- Ensure the safe management of medicines, medical equipment and security of prescription forms.
- Ensure effective management of infection prevention and control.
- Ensure the practice governance arrangements include audits to monitor quality and safety, including completed clinical audits.
- Ensure the practice governance arrangements include a system of risk assessment and management, including analysis of significant events and improved staff awareness of incidents that require reporting.

Action the service SHOULD take to improve

- Review the training requirements for staff in keeping mandatory training updated.
- Review the arrangements for undertaking timely staff appraisals.

Dr Chandrika Ramu

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and the team included a GP specialist advisor, and a practice manager specialist advisor.

Background to Dr Chandrika Ramu

Dr Chandrika Ramu provides medical care from 8.30am to 1.30pm and 2.30pm to 6.30pm on Monday, Tuesday, Wednesday and Friday. On Thursdays, appointments are available from 8.30am until 1pm. The practice operates extended opening hours until 8pm on Wednesday evenings. The practice is situated in the town of Sittingbourne in Kent and provides a service to approximately 2,400 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GP. The practice has more patients registered up to the age of 18 than the national average, although it is line with the local average. There are fewer patients over the age of 65 registered at the practice than both the local and national averages, including older patients over the age of 85. The number of patients recognised as suffering deprivation for this practice, including income deprivation, is slightly lower than the local and national averages.

The practice has one single-handed female GP, who employs a part-time female health care assistant. There is no regular provision of a male GP. Regular locum practice nurses support the GP in providing clinical services. There are two administration staff, and a practice manager.

The practice does not provide out of hours services to its patients and there are arrangements with another provider (MEDDOC) to deliver services to patients when the practice is closed. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from:

Dr Chandrika Ramu

95 High Street

Milton Regis

Sittingbourne

Kent. ME10 2AR.

Why we carried out this inspection

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

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

This provider had not received a comprehensive inspection before and that was why we included them.

Detailed findings

How we carried out this inspection

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 19 May 2015. During our visit we spoke with a range of staff including the GP, the health care assistant, one member of the administration staff team and the practice manager. We spoke with patients who used the services at the practice and we reviewed comment cards where patients shared their views and experiences of the service.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

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

We reviewed safety records for the last three years. These showed the practice had managed incidents consistently over time and could demonstrate a safe track record over the long term, although the number of recorded incidents had reduced in the last year compared to previous years.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events. We saw records of significant events that had occurred during the last three years and two had been recorded during the previous year. Although staff understood the system for reporting incidents and events, there was no common understanding of what was a significant event. On speaking with staff, we found that there had been significant events, which although had been resolved without harm to patients, had not been appropriately reported and recorded as such. Significant events were discussed at general practice meetings and there was evidence that the practice had learned from these. All staff, including reception and administrative staff, knew how to raise an issue for consideration at the meetings and said they felt encouraged to do so.

We tracked two significant events and saw records were completed in a comprehensive and timely manner and actions were taken as a result. For example, the practice had investigated a recent incident of verbal abuse from a patient and following a discussion with all staff at a practice meeting, actions had been agreed and implemented.

National patient safety alerts were disseminated and monitored by a senior member of staff within the practice. There was a system to help ensure that all safety alerts were seen and actions taken by relevant staff, including drug alerts and medical device alerts.

Reliable safety systems and processes including safeguarding

The practice had systems and arrangements for safeguarding vulnerable adults and children who used the services. There was a policy for safeguarding children and vulnerable adults which clearly set out the procedures for staff guidance and contact information for referring concerns to external authorities. The policy was available to all staff on the practice computer, as well as in a hard copy file and reflected the requirements of the NHS and social services safeguarding protocols.

The GP and Practice Manager were the designated leads in overseeing safeguarding matters and had received the necessary training (level three) to fulfil their roles in managing safeguarding issues and concerns within the practice. The staff we spoke with were all knowledgeable in how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies. The training records demonstrated that most staff had undertaken children's safeguarding training to the required levels. Records confirmed however, that administration staff had not undertaken training in either safeguarding children or vulnerable adults. Additionally, the health care assistant had not undertaken children's safeguarding at level two, although training had been arranged.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. Staff liaised with relevant agencies, including the health visitor and social services to share information in relation to concerns that were identified within the practice. We saw minutes of meetings where safeguarding concerns were discussed.

The practice had a chaperone policy. A chaperone is a person who accompanies a patient when they have an examination and we saw that the practice policy set out the arrangements for those patients who wished to have a chaperone. Patients were made aware that they could request a chaperone, and details were displayed within the practice. Administration staff did occasionally undertake chaperone duties and the practice was in the process of obtaining Disclosure and Barring Service (DBS) checks for

these staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a protocol for ensuring that medicines were kept at the required temperatures and checks of refrigerators used to store medicines had been carried out. Records of daily temperatures were also kept.

Although staff told us that medicines kept in the practice were checked, we found no evidence or records to demonstrate that checks had be carried out and who by. All the medicines we checked were within their expiry dates and fit for use. Expired and unwanted medicines were disposed of in line with waste regulations. The practice did not keep controlled drugs.

Following our inspection, the practice provided evidence to demonstrate they had a process for the health care assistant to administer vaccines using patient specific directions that had been authorised by the GP, in line with legal requirements and national guidance. A qualified independent nurse prescriber also administered vaccines and other medicines. Records confirmed that appropriate training and regular updates of their clinical competencies had been undertaken.

All prescriptions were reviewed and signed by a GP before they were given to the patient. However, blank prescription forms were not always handled in accordance with national guidance, as the practice did not have a system to help ensure prescription pads were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The practice was clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow. For example, hand hygiene and the management of sharps / needle stick injuries. The practice had not designated a member of staff who had lead responsibility for infection prevention and control. Infection control audits had not been undertaken to identify potential infection control risks and any follow-up actions required to help minimise potential risks to patients, staff and others.

Staff were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control. Personal protective equipment including disposable gloves, aprons and coverings were available and staff we spoke with were able to describe how they would use these to comply with the practice's infection control policy. Records showed that staff had not received updated infection control training.

The practice had cleaning schedules and cleaning records were kept. Notices about hand hygiene techniques were displayed for staff guidance and sufficient supplies of hand soap, hand gel and paper towel dispensers were available in treatment rooms.

The practice had not considered the risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings) and had not undertaken a risk assessment to determine any required actions to reduce the level of risk. Following the inspection, the practice confirmed that a date had been identified for a specialist contractor to undertake a risk assessment.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and equipment maintenance logs and other records confirmed this. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Records confirmed evidence of calibration of relevant equipment, for example, blood pressure monitoring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff, including protocols for checking qualifications, professional registration and obtaining references. Records showed that recruitment checks had not always been undertaken when employing staff. For example, criminal record checks through the Disclosure and Barring Service (DBS) had not been undertaken for the health care assistant or any of the administration staff, including those who sometimes

undertook chaperone duties. A risk assessment had not been undertaken to determine the roles required to have DBS checks, although the practice was in the process of applying for DBS checks for all staff. Following the inspection, documentary evidence was received confirming that employment checks had been undertaken for locum nursing staff resourced directly by the practice, including verification of their professional registration, qualifications and DBS checks.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a system to help ensure that enough staff were on duty and arrangements for members of staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff to keep patients safe. Patients we spoke with told us they felt there were enough staff in the practice to support their care and treatment needs.

Monitoring safety and responding to risk

The practice had a health and safety policy, including procedures and information for staff guidance. Induction plans for new staff included health and safety information. There was a system governing security of the practice. For example, visitors were required to sign in and out using the dedicated book in reception. There were security locks on doors leading to staff areas, to prevent unauthorised access.

Staff we spoke with told us they used systems to identify and respond to changing risks to patients, including deteriorating health and well-being. Emergency referrals were made for patients who had experienced a sudden deterioration or urgent health problem. The practice monitored repeat prescribing for patients receiving medicines for mental health problems, for example, weekly prescribing for those at risk of overdose. The practice had a process for following up patients who had attended hospital or discharged from hospital following an unplanned admission.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage some emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used in cardiac emergencies). Staff we spoke with knew the location of this equipment, although records were not kept to confirm that it was regularly checked and we found an oxygen face mask that was out-of-date.

Emergency medicines were available in a secure area of the practice and all staff knew where they were kept, although emergency medicines and medical equipment were stored in different areas. Following the inspection, arrangements were made to keep all emergency items in one place. There were processes to check whether emergency medicines were within their expiry date and suitable for use, although these were not recorded. All the medicines we checked were in date and fit for use.

The practice had not carried out a fire risk assessment and did not have a fire safety action plan that identified the actions required to maintain fire safety. Staff employed at the practice had not received fire safety training and had not practiced regular fire drills.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, interruption to utilities and loss of the computerised records system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP we spoke with was familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. They used guidance and diagnostic tools available on the computer to access the most up-to-date documents.

The practice engaged with the clinical commissioning group (CCG) and the GP met with other practices in the local area on a monthly basis. We found from our discussions with the GP and the health care assistant that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, patients with diabetes received regular health checks. Feedback from patients confirmed they were referred to other services or hospital when required.

We reviewed data for the practice's performance for prescribing, which showed that the practice was either in line or better than similar practices for national prescribing indicators, including anti-inflammatory and anti-biotic medicines. The practice met regularly with a prescribing advisor from the CCG to help ensure updated guidance was followed.

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

Management, monitoring and improving outcomes for people

The practice kept registers to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions including asthma, heart disease, and diabetes. Registers were kept under review and meeting minutes demonstrated that information was shared and discussed regarding the health care needs of specific patients, as well as any additional risk factors that may need to be identified on the patient records system. For example, patients experiencing poor mental health had their medicines monitored closely and in some cases, weekly consultations were arranged with the GP, who prescribed medicines on a weekly basis.

All patients over the age of 75 had a named GP and had care plans that were regularly reviewed. The practice also had processes to follow-up those patients discharged from hospital. For example, the GP carried out a review of their medicines and health care needs, as well as updating the patient records system. Structured annual reviews were also undertaken for people with long term conditions. For example, recent data showed that 88% of patients with a diagnosis of dementia had received a face-to-face review in the last year.

The practice had undertaken some clinical audits. The GP we spoke with told us that these 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).

We looked at three audits undertaken in the last year that had been generated by information from the QOF data. For example, an audit was carried out to check that treatment and care was being managed effectively for patients with a specific heart condition. There was some evidence that the practice had gathered information from the patient records and reviewed the results. A full audit cycle had not been completed to check that outcomes had been improved for these patients on an on-going basis. Other audits had also been undertaken, including an audit relating to medicine prescribing for a specific condition, although a re-audit to check the results had not been completed.

The available QOF data showed that the practice had performance indicators that were higher than the national average in many areas. Indicators were higher in all areas for patients receiving care and treatment for diabetes. For example, 97% of patients with diabetes had received an influenza vaccination in the preceding year, compared to 93% nationally.

Good

Are services effective?

(for example, treatment is effective)

Other QOF data also showed that the practice was performing well. For example, 89% of patients diagnosed with high blood pressure had undergone a recent blood pressure check where the results had been within a safe range, compared to 83% nationally.

The practice had a palliative care register and had regular multi-disciplinary meetings to discuss the care and support needs of patients and their families, although these were not always recorded. QOF data indicated that multi-disciplinary review meetings were held at least every three months to discuss all patients on the register.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and the computer system provided an alert for those patients who required a medicines review.

Effective staffing

Practice staff included a GP, a health care assistant (HCA), managerial and administrative staff. The practice used locum nurses to support some of the specialist clinics that were held at the practice. Records showed that staff attended a range of training to help ensure their skills were kept up-to-date, including mandatory courses such as annual basic life support, although not all staff had attended training in safeguarding and infection control. The GP, HCA and locum practice nurse had completed specialist clinical training appropriate to their roles. For example, diabetes, asthma, family planning, and updates in childhood immunisations and vaccinations.

All the staff we spoke with felt they received the on-going support, training and development they required to enable them to perform their roles effectively. The practice had provided staff training for relevant courses. For example, the reception / administration staff had been supported and funded to undertake a national qualification at an enhanced level in customer care. Records showed that staff had not received an annual appraisal in the previous year, although staff felt that informal discussions had enabled them to identify training and learning objectives for the coming year, that were relevant to their roles.

The GP was up to date with their annual continuing professional development requirements, had undergone an annual appraisal and 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Working with colleagues and other services

The practice worked with other health care professionals and partner agencies, including district nurses and social services. Meetings were held with the palliative care services team on a quarterly basis, who provided specialist support for patients with palliative care needs. Care plans were in place for patients with complex needs and were shared with other health and social care workers as appropriate.

The practice worked and liaised with the local midwifery team, referring expectant mothers for ante-natal care. Support for new mothers and babies, including post-natal and new baby checks were provided at the practice by the GP. The practice also liaised regularly with a local drop-in centre for people in vulnerable circumstances, who required support for alcohol and drug dependence, many of whom were registered patients at the practice.

The practice 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 procedures for staff to follow in relation to passing information on, as well as reading and acting on any issues arising from communications with other care providers on the day that they were received. The GP who saw these documents and results was responsible for the action required and the staff we spoke with felt the system worked well.

Information sharing

There were systems to help ensure that patient information was shared with other service providers, including hospital services. There was a system to refer patients to other services, including the 'Choose and Book' referral system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). We were told that 99% of referrals were made in this way.

The practice had systems to provide staff with the information they needed. An electronic patient record

system was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system and told us the system worked well. The system enabled scanned paper communications, such as those from hospital, to be saved in the patients' electronic records.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how consent should be recorded. Mental capacity assessments were carried out by the GP and recorded on individual patient records.

Although formal training in the Mental Capacity Act 2005 had not been undertaken, staff were able to demonstrate their awareness and gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. Clinical staff demonstrated an 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).

The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff.

Health promotion and prevention

The practice offered and promoted a range of health monitoring checks for patients to attend on a regular basis. For example, cervical smear screening and general health checks including weight and blood pressure monitoring. We spoke with the GP and health care assistant who conducted various clinics for long-term conditions and they described how they explained the benefits of healthy lifestyle choices to patients with long-term conditions such as diabetes, asthma and coronary heart disease. All new patients who registered with the practice were offered a consultation to assess their health care needs and to identify any concerns or risk factors. The practice also offered NHS health checks to all patients aged 40-75 and health care issues or concerns were followed-up by the GP to help ensure on-going health care needs were appropriately managed.

The practice had a system for informing patients when they needed to come back to the practice for further care or treatment or to check why they had missed an appointment. For example, the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us they were contacted by the practice to attend routine checks and follow-up appointments.

Health care screening programmes were offered at the practice, including sexual health screening. For example, chlamydia testing was offered to patients and recent data showed that the practice had improved the uptake of tests in the last year. The practice had undertaken the highest number of tests in the local area, and compared well to other areas in the region.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 99% of patients over the age of 16 and had offered smoking cessation advice and support to 96% of patients who smoked in the last year. Recent data also indicated that 88% of patients diagnosed with dementia had received a face-to-face review in the last year, compared to 84% nationally.

Vaccination clinics were promoted and held at the practice, including a seasonal influenza vaccination for older people and those with chronic / complex needs. Recent data showed that 73% of patients over the age of 65 and 54% of patients in other 'at risk' groups had received the vaccination, which was in line or above the national averages of 73% and 52% respectively. The practice also carried out a full range of immunisations for children. The available data showed that the majority of childhood immunisation indicators were higher than the local averages. For example, the immunisation rate for the MMR vaccination was 97%, compared to the local average of 93%.

There was a range of information leaflets and posters in the waiting area for patients, promoting healthy lifestyles, for example, smoking cessation, and weight management.

Good

Are services effective?

(for example, treatment is effective)

Information about how to access other health care services was also displayed to help patients access the services they needed, for example, dementia awareness and cancer support groups.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice in relation to patient satisfaction. Information from the national patient survey undertaken in 2014 showed that patients felt they were treated with dignity and respect, and that the staff treated them with care and concern.

The information showed that patients had rated the practice well in all areas when compared to other practices within their local area. For example, the data showed that 80% of respondents said that the GP they saw or spoke to was good at treating them with care and concern, compared to the local average of 76%. Similarly, 86% of respondents said that the nurse they saw or spoke to was good at treating them with care and concern, compared to the local average of 74% and the national average of 78%.

We also reviewed the results from the most recent patient survey undertaken by the practice in 2014. The information showed that respondents rated the practice well when compared to national data. For example, 94% of patients responded positively when asked if they felt the staff were polite and made them feel at ease.

We spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided and that the practice was very caring and understanding of their needs. We observed that reception staff were welcoming to patients, were respectful in their manner and showed a willingness to help and support patients with their requests. Data from the national patient survey showed that 98% of respondents said that they found the receptionists at the practice helpful, compared to the local average of 86% and the national average of 87%.

Patients had completed comment cards prior to our inspection, to tell us what they thought about the practice. We received 47 completed cards, the majority contained very positive comments. 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. Only three comment cards contained less positive comments, but there were no common themes to these.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consultation 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.

The practice had a confidentiality policy, which provided guidance for staff in how to protect patients' confidentiality and personal information. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality and described how they followed the policy in practice. The reception area was designed in a way to help maintain confidentiality when staff were speaking on the telephone. A notice was displayed to inform patients they could request a room for private conversations with staff if they wished.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed there had been a positive response from patients to questions about their involvement in planning and making decisions in relation to their care. For example, data from the national patient survey showed that 77% of respondents said GPs were good at involving them in decisions about their care, compared to the local average of 68% and the national average of 74%. Similarly, the data showed that 76% of respondents said nurses were good at involving them in decisions about their care, compared to the local average of 65% and the national average of 66%.

When we spoke with patients, they told us they felt involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. They said GPs and nurses took the time to listen and explained all the treatment options and that they felt included in their consultations. Data from the national patient survey showed that 91% of respondents felt that nurses were good at explaining tests and treatments, compared to the local average of 74% and the national average of 77%. Patients told us they felt able to ask questions and never felt rushed. Patient feedback from the comment cards we received was also very positive and was consistent with these views.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

We observed that staff were supportive in their manner and approach towards patients. Patients told us that staff gave them the help they needed and that they felt able to discuss any concerns or worries they had.

Patient information leaflets, posters and notices were displayed that provided contact details for specialist groups offering emotional and confidential support to patients and carers. For example, counselling services and bereavement support groups. The practice's electronic patient records system alerted GPs if a patient was also a carer. There was a range of information available for carers to help ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs. The staff we spoke with explained that a range of services were available to support and meet the needs of different patient population groups and that there were systems to identify patients' needs and refer them to other services and support if required. For example, referring patients with mental health needs to specialist groups who provided counselling support services. The practice GP was flexible in seeing patients with mental health problems at a time to suit them and had encouraged a 'drop-in' approach so that their health care needs could be monitored. Patients we spoke with told us they were referred promptly to other services for treatment and test results were available quickly.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. The patient participation group (PPG) had not been active in recent years and the practice had been seeking new members and patient representatives to re-form a new PPG. In the absence of a PPG, the practice had taken account of the views of patients from other sources, including the NHS friends and family test questionnaires, comments and general feedback received. This had resulted in some changes to the reception area, including a decision to change some of the chairs in the patient waiting area, and the introduction of magazines.

Tackling inequity and promoting equality

The practice was located in premises that provided level access to the treatment and consultation rooms. The waiting area was large enough to accommodate patients with wheelchairs and prams and accessible toilet facilities were available for patients attending the practice. Interpretation services were available by arrangement for patients who did not speak English. The practice had taken account of the difficulties that some patients had in accessing the premises when using wheelchairs. A decision had been taken and plans had been implemented to renew the ramp at the front of the premises to provide easier access for those patients who had mobility difficulties.

The practice took account of the needs of different patients in promoting equality. Although staff had not undertaken formal equality and diversity training, they were able to demonstrate an awareness of the needs of different patient groups. For example, identifying those patients with learning disabilities to help ensure they received appropriate care and support, including an annual assessment of their health care needs. Follow-up letters were sent to patients who did not attend for annual reviews.

Access to the service

Appointments were available from 8.30am to 1.30pm and from 2.30pm to 6.30pm on Monday, Tuesday, Wednesday and Friday. On Thursdays, appointments were available from 8.30am until 1pm. The practice operated extended opening hours until 8pm on Wednesday evenings, which provided flexibility for working patients outside of core working hours and school hours for children. Outside of these hours, patients were requested to contact the 'out of hours' service if urgent medical treatment was required.

The practice offered a good mix of pre-bookable and 'book-on-the-day' GP appointments, including flexibility to provide urgent or emergency appointments for patients to be seen on the same day. Patients we spoke with said that the appointments system worked well, that they had not experienced any problems obtaining an appointment and that these were usually at a convenient time for them.

Patients could book an appointment by telephone or in person. Home visits were arranged for those who found it difficult to attend the practice, for example, older patients who were housebound. Longer appointments were available for patients who needed them, for example, if they had long-term conditions or complex health care needs.

Patients we spoke with all expressed confidence that urgent problems or medical emergencies would be dealt with promptly, that staff knew how to prioritise appointments for them and that they would be seen the same day. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment. For example, the practice had a system to identify and prioritise patients with poor mental health who required urgent access to a GP appointment.

There were arrangements to help ensure patients could access urgent or emergency treatment when the practice was closed. Information about the 'out of hours' service

Good

Are services responsive to people's needs?

(for example, to feedback?)

was displayed inside and outside the practice and was also included in the patient information booklet. A telephone message informed patients how to access services if they telephoned the practice when it was closed. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

Information from the national patient survey showed that patients responded very positively to questions about access to appointments and rated the practice well in all areas. For example, 97% of respondents said they found it easy to get through to the practice on the telephone, compared to the local average of 66 % and the national average of 72%. Similarly, 99% of respondents said that they were able to get an appointment the last time they tried, compared to 83% locally and 85% nationally. When asked if the appointment was convenient, 99% responded positively, compared to the local average of 90% and the national average of 92%.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. There was a complaints policy and a procedure that was in line with NHS guidance for GPs and there was a designated responsible person who handled all complaints in the practice.

Information was available to help patients understand the complaints system. The complaints procedure was included in the practice information booklet and a complaints leaflet was available in the patient waiting / reception area. There were also questionnaires for patients' to complete to provide comments and feedback to the practice. We looked at one complaint that had been received in the last year and found that this had been satisfactorily investigated and dealt with in a timely way and in accordance with the practice policy. The complainant had received a written apology.

The practice had reviewed the complaint and discussed it with staff, to identify ways to help avoid a similar incident happening again. This had included a review of the options given to patients when using the 'choose and book' referral system and how this was explained to patients.

Patients we spoke with told us that they had never had cause to complain but knew there was information available about how and who to complain to, should they wish to do so.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a statement of purpose, which set out the aims and objectives of the practice, which were to provide good quality care and treatment for the patients who used its services. When speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose of providing good quality care to all patients.

Staff told us they understood their roles and responsibilities in helping to ensure the practice achieved its aims and objectives and felt they contributed to the overall quality of care that patients received.

Governance arrangements

The practice had a leadership structure with members of staff in lead roles. For example, there was a lead for safeguarding and information governance. We spoke with four members of staff who were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns or issues.

The practice held monthly meetings, that included all staff in the practice. Discussions related to significant events, safeguarding concerns and other matters that staff wished to raise. The practice also held multi-disciplinary meetings with other care providers and specialists, to discuss individual patients and the management of their care.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data indicated that the practice was performing either in line or above national standards in many areas. Actions for improvement were discussed and agreed in practice meetings. For example, a member of staff had lead responsibility for following-up patients who had not attended for health care reviews, checks and assessments.

The practice had undertaken some clinical audits to monitor quality and systems to identify where action should be taken to improve outcomes for patients. However, information from the audits did not clearly identify the findings and any subsequent changes that had been implemented as a result. There were no second audits or plans to re-audit, in order to assess the impact of any changes made to maintain or improve outcomes for patients.

The practice did not have a system to undertaken other audits to monitor the quality and safety of the services. For example, a training audit or plan to identify the training undertaken and required by staff, including some areas of mandatory training, such as fire safety, safeguarding and infection control. There was no formal system to audit the checks undertaken for locum staff working in the practice. For example, professional registration checks with the nursing and midwifery council (NMC) for nursing staff, to monitor that these were kept up-to-date.

The practice had a number of policies and procedures to govern activity and these were available on the computer for staff guidance and reference. We looked at seven of these and saw that they had been reviewed in the last year.

The practice did not have an established system for managing and mitigating risks in relation to the premises, to help keep staff, patients and others safe. The practice did not have a risk log or a process to identify and record how risks were monitored and managed on an on-going basis, including actions required by staff to minimise risks. For example, the practice had not undertaken a fire risk assessment to identify how fire safety was managed.

Leadership, openness and transparency

We spoke with the practice GP who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. Staff we spoke with told us they felt there was an 'open door' culture, that GPs were approachable, and that they felt supported and able to approach senior staff about any concerns they had. They said there was a good sense of team work within the practice and communication worked well.

The practice manager was responsible for human resource policies and procedures. These included a grievance policy, recruitment policy and sickness / absence policy, which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice also had a whistleblowing policy which was available to all staff on any computer within the practice.

Are services well-led?

Requires improvement

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

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

The practice did not have an active patient participation group (PPG), although they had promoted the benefits of having a PPG and advertised for members. In the absence of a PPG, the practice had sought feedback, views and comments from patients in other ways. For example, the NHS friends and family test questionnaires and a suggestion / comment box was available in the reception area. A recent survey had also been undertaken by the practice, of patients who used the services and health care professionals who worked with the practice. Results from the survey had been mainly positive, although the practice planned to review the results and develop an action plan to implement any required changes in the coming year.

All staff we spoke with said they felt their views and opinions were valued and they were listened to. They told us they were positively encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients. Minutes from the monthly practice meetings showed that staff participated and contributed their views.

Management lead through learning and improvement

Staff told us that the practice was very supportive of training to help maintain their clinical competencies and other learning and development. We looked at three staff files and saw that they contained details of continuing professional development. This included updates and further learning in clinical practice, as well as enhanced learning and development for administration staff. There were no records to show that appraisals had been undertaken in the last year for any of the staff in the practice.

The practice had recorded significant events in the last year, although these were low in number. The outcomes were shared with staff to help ensure lessons were learned and changes acted on. There were no records to demonstrate that there had been an analysis or review of significant events to identify trends to help improve outcomes for patients who used the services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The provider did not have established recruitment procedures that operated effectively to ensure that information was available in relation to each person employed for the carrying on of the regulated activities, because the provider had not undertaken Disclosure and Barring Service (DBS) checks for staff employed as specified in Schedule 3, and the risks had not been assessed in relation to this. Regulation 19(3)(a) – Schedule 3

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for service users in relation to the proper and safe management of medicines, because the provider did not keep a record of the medicine and medical equipment checks undertaken by staff and did not have a system for the security and tracking of blank prescription forms. Regulation 12(1)(2)(g) AND Care and treatment was not provided in a safe way for service users in relation to assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated, because the staff employed to carry on the regulated activities had not received updated infection control training and there was not a designated lead

Requirement notices

member of staff with enhanced training for infection control. Infection control audits had not been undertaken to identify, assess and mitigate risks, including an assessment of the risks associated with legionella bacteria.

Regulation 12(1)(2)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider had not established systems or processes that were effectively operated to ensure that the quality and safety of the services provided in the carrying on of the regulated activities were assessed, monitored and improved, because the provider had not carried out audits, including the completion of clinical audits. Regulation 17(1)(2)(a) AND The provider had not established systems or processes that were effectively operated to ensure that the services provided were assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others, who may be at risk which arise from the carrying on of the regulated activities, because the provider did not have a system to assess and manage risks. The provider did not have a system or process to analyse significant events and there was no common understanding amongst the staff in recognising reportable significant events and incidents. The provider had not undertaken a fire risk assessment to monitor and manage the risks associated with fire safety. Regulation 17(1)(2)(b)