Dr Bhupinder Batra

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.

Contents

Summary of findings

Overall summary

The practice had safety measures in place however some of these relating to staffing required improvement. Records showed all staff had received suitable training, including in Basic Life Support. They were aware of the importance of reporting incidents to ensure they were properly investigated. Disclosure and Barring Service (DBS) checks had not been carried out on two non-clinical staff members. Risk assessments had not been carried out to ensure these members of staff were suitable for employment without a DBS check. We noted these members of staff acted as chaperones and therefore may be eligible for DBS checks. We have asked the practice to take action in relation to this.

Improvements were required to make the service more effective. Procedures were in place to ensure care and treatment was delivered in line with appropriate standards. However, because staff had not had appraisals for about three years, there was no formal process to identify training and professional development needs. We have asked the practice to take action in relation to this.

The practice was caring however some improvement was required. Responses from patients we spoke with and comment cards we received showed that the practice staff treated patients with compassion, dignity and respect. However, we noted that staff acted as chaperones although they had not received training to ensure they understood their role and that the service being offered was effective. We have asked the practice to take action in relation to this.

The practice had measures in place to be responsive and meet the needs of its patient group. However some improvements could be made in relation to the collection and monitoring of complaints.

We found clear and visible leadership and lines of accountability. Governance arrangements were in place and there was effective use of the Patients Reference Group (PRG) to gain patient feedback. However we found regular supervision and appraisals were not taking place. Peer reviews between clinical staff were not taking place, however the practice participated in a local “practice to practice” peer review process whereby a GP from another local practice visited the practice, reviewed various issues and offered feedback.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had safety measures in place however some of these required improvement. The practice had systems in place to report and record incidents. Records showed all staff had received training in Basic Life Support. Staff were aware of the importance of reporting incidents to ensure they were properly investigated. They also demonstrated that learning points were and shared to ensure there was no repetition.

Permanent clinical and non-clinical staff had received suitable, relevant safeguarding training. However, there was no evidence locum GPs had received safeguarding training. Disclosure and Barring Service (DBS) checks had not been carried out on two staff members. We noted these members of staff acted as chaperones and therefore may be eligible for DBS checks. Risk assessments had not been carried out to ensure these members of staff were suitable for employment without a DBS check. We have asked the practice to take action in relation to this.

Are services effective?

The practice was effective. Procedures were in place to ensure care and treatment was delivered in line with appropriate standards. The practice employed qualified and competent staff. Staff training records showed staff received mandatory training relevant to their role. However, because staff had not had appraisals for about three years, there was no formal process to identify training and professional development needs.

The practice worked collaboratively with other services to support and enable multi-disciplinary working. Health information was available to patients and the practice supported patients to live healthier lives.

Are services caring?

The practice was caring. Responses from patients we spoke with and comment cards we received showed the practice staff treated patient's with compassion, dignity and respect. We noted staff were acting as chaperones although they had not received training to ensure they understood their role and that the service being offered was effective.

Are services responsive to people's needs?

The practice had measures in place to be responsive and meet the needs of its patient group, however some improvements could be

Summary of findings

made. The practice planned and delivered services to meet the needs of different patients. Patients we spoke with and responses on comment cards we received showed patients were happy with their care and treatment and felt their needs were being met.

The appointment system had recently been reviewed to try and better meet patients needs. However, recent survey results showed some patients remained dissatisfied with the availability of appointments. Verbal complaints were not recorded and as such opportunities to improve the service could be missed.

Are services well-led?

The practice was well led with clear and visible leadership and lines of accountability. Governance arrangements were in place and there was effective use of the Patients Reference Group (PRG) to gain patient feedback. There were clear staff values and ethos which focussed on quality. Whilst staff reported feeling valued and well supported, regular supervision and appraisals would provide staff with an opportunity to discuss training needs, speak to the leadership in confidence and to have a structured and measurable approach to their career development. Peer review took place between the practice's GPs and another local GP.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The practice provided a safe, effective, caring responsive and well led service older patients. Processes and procedures were in place to ensure their particular health needs were met.

People with long-term conditions
The practice provided a safe, effective, caring, responsive and well led service to patients with long term conditions. Measures were in place to ensure sufficient monitoring and support were available and patients were assisted to manage their own health condition. Where failings were identified, appropriate intervention and referral took place.

Mothers, babies, children and young people
The practice provided a safe, effective, caring, responsive and well led service to mothers, babies, children and young people. There were a large number of children registered at the service. Staff recognised and understood the needs of this patient group. Staff had received safeguarding training to help ensure the safety of children. There was effective multi-disciplinary engagement to ensure these patient's needs were met.

The working-age population and those recently retired
The practice provided a safe, effective, caring, responsive and well led service to patients of working age and those recently retired. They had responded to patient feedback and provided more appointments at convenient times to meet the needs of this population group and make the service more accessible to them.

People in vulnerable circumstances who may have poor access to primary care
The practice provided a safe, effective, caring, responsive and well led service to people in vulnerable circumstances who may have poor access to primary care. Homeless patients were able to use the practice address to receive mail and thus ensure hospital appointments were not missed. Annual health checks were conducted for patients with a learning disability.

People experiencing poor mental health
The practice provided a safe, effective, caring, responsive and well led service to patients known to experience poor mental health. A

process to ensure regular reviews were carried out was in place. The practice worked collaboratively with the local mental health team and other relevant organisations to ensure patient's needs were met.	

Summary of findings

What people who use the service say

During the inspection we spoke with seven patients and received comment cards from 14 patients. The comments we received were positive. Patients said they were treated with compassion, dignity and respect by staff although one patient felt a disagreement with a receptionist had led to him being treated unfairly at times. Patients said they were listened to and that staff always had enough time for them. They were not routinely turned away if they were late and were treated with understanding.

Patients told us their health needs were met and they received sufficient support to understand and manage their conditions.

We noted from the most recent patient survey that some patients remained dissatisfied with the appointments system. The practice continued to monitor and review the system to try and meet the varying needs of its patient group. They had put measures in place to reduce the number of wasted appointments so that more patients could get appointments at times that suited them.

Areas for improvement

Action the service MUST take to improve

- Ensure relevant pre-employment checks are carried out for all staff including Disclosure and Barring Service (DBS) checks or an effective risk assessment and that complete staff recruitment records are maintained;
- Ensure suitable arrangements are in place to ensure staff are adequately supported through appropriate professional development, supervision and appraisal. This includes ensuring staff are supported in relation to their responsibility to act as chaperones;
- The process for receiving complaints must be improved to ensure verbal complaints are captured as well as written complaints in order to effectively assess the quality of the service provide.

Action the service SHOULD take to improve

- Formal training about the Mental Capacity Act 2005 could be undertaken by clinical staff to ensure understanding of their role in respect of best interest decisions and to better meet the needs of older patents, patients with long term conditions (particularly dementia) and those experiencing poor mental health.

Dr Bhupinder Batra

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team also included a CQC inspector, a health psychologist and an expert by experience.

Background to Dr Bhupinder Batra

Dr Bhupinder Batra is a general practice (GP) surgery that provides NHS primary care services to around 6000 registered patients in New Cross within the NHS Lewisham Clinical Commissioning Group (CCG) area. NHS Lewisham Clinical Commissioning Group (CCG) is made up of 44 local GP surgeries.

Lewisham is a London borough in south-east London. In Lewisham deprivation levels are significantly worse than the England average. Demographic information for Lewisham shows the number of people between 20 and 39 and children under ten is significantly higher than the England average. Census data shows an increasing population and a higher than average proportion of Black and Minority Ethnic residents in Lewisham. Information for Dr Bhupinder Batra shows a lower than average proportion of patients registered aged 65 and over.

Dr Bhupinder Batra operates from the first floor of the Waldron Health Centre Stanley Street, London, SE8 4BG. The practice is registered with the CQC as a partnership. The lead GP (male) is one of the partners and is also the registered manager. The other partner is the practice manager. Other clinical staff included a female salaried GP, two locum GPs and a practice nurse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

Detailed findings

We carried out an announced visit on 09 July 2014. During our visit we spoke with a range of staff including GPs, the practice nurse, practice manager reception and administrative staff. We also spoke with the dietician who was based at the practice one day a week.

We also spoke with patients who used the service and their carers and/or family members. We observed how people were being cared for and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

The practice had systems in place to report and recording incidents. Staff were aware of the importance of reporting incidents to ensure they were properly investigated. They also demonstrated that learning points were identified and shared to ensure there was no repetition.

Permanent clinical and non-clinical staff had received suitable, relevant safeguarding training. However, there was no evidence locum GPs had received safeguarding training. Risk assessments had not been carried out to ensure these members of staff were suitable for employment without a DBS check. Records showed all staff had received training in Basic Life Support.

Safe patient care

The practice had systems in place to report and record incidents. Staff reported any incident to the senior partner. Non-clinical incidents were managed by the practice manager, clinical incidents by the senior partner. Staff we spoke with were aware of their responsibility to report incidents. We were told serious events were brought to the attention of the whole team immediately, rather than at the following team meeting. One recent incident in relation to a medication error we were told about had not been recorded or communicated with other staff. We were told this was because the incident had happened recently and the clinician had not yet had the opportunity to report it.

Records showed that reports of incidents included details of what had happened including dates, dates of the review meeting and who had attended and the issues that had been identified. They also detailed what lessons had been learnt and preventative measures put in place as a result. This information was made available on the computer system, accessible to all staff.

The practice manager was responsible for carrying out risk assessments. Examples included fire and health and safety. We were told these were carried out annually for each consulting room, administration area and reception area.

Records showed all staff had received training in Basic Life Support and this was updated regularly.

Learning from incidents

Staff were aware of the importance of reporting incidents to ensure they were properly investigated. They also demonstrated that learning points were identified and shared to ensure there was no repetition. Incident reports showed action plans were devised following any incidents and audits were carried out to ensure staff knew what to do to avoid a recurrence. One such incident report related to a fault with the computerised document system. This fault meant staff could not access clinical letters on the system which required action by clinicians. As a result of this incident an action plan was put in place to ensure alternative options were available, thus reducing sole reliance on computerised records.

Safeguarding

The practice had appropriate policies and procedures in place to ensure children and vulnerable adults were protected. These policies were available to all staff through the computer database. The policies covered types and signs of abuse and how to raise alerts. Records showed that non-clinical staff had received suitable, relevant training. Staff we spoke with understood their role in relation to identifying and reporting any concerns about abuse. They were aware that the senior partner was the practice lead for safeguarding. They were also aware of external organisations where they could report concerns. Contact numbers for the local child protection team were available on the computer database. GPs provided information for case conferences by fax if they could not attend in person. The lead GP and salaried GP had received safeguarding training. However, in relation to the locum GPs, we were told they had received training but there was no available evidence of this at the time of our inspection.

Monitoring safety and responding to risk

The practice had 6000 patients on their list. It was staffed by three GPs (one partner, one salaried and one locum). In addition there was a practice nurse and dietician based on site. There was also a practice manager, a deputy practice manager and four administrative/reception staff. Reception staff said they were able to ensure reception was adequately covered between them. The manager told us during particularly busy periods they were able to use administrators to assist on reception or draft in bank staff who were familiar with the practice. They were also able to run extra clinics, for example during the flu season.

The practice nurse worked 28 hours a week, spread over five days. They were responsible for new patient health

Are services safe?

checks, diabetes and asthma reviews, travel and baby immunisations, smear tests and wound dressings. Whilst nurse cover was not available at all times we were told the hours of cover were sufficient to meet patients needs.

The practice had a policy regarding dealing with medical emergencies. All staff were aware of this policy and where to access it.

Medicines management

The practice had policies and procedures in place to support the safe management of medicines. Emergency medicines were stored securely and the medicines were all within their expiry date. Records showed fridges storing vaccinations were checked daily to ensure they were within the appropriate temperature range of two to eight degrees Celsius. These fridges were kept locked within a locked treatment room.

Information received prior to the inspection suggested there were anomalies in relation to the practice's prescribing of nonsteroidal anti-inflammatory drugs (NSAIDs). We raised this with the practice who told us they had had an issue with this but that following review by a prescribing adviser in 2013, prescribing of NSAIDs had improved. We saw records of prescribing rates for 2013 compared to 2009-10 and 2010-11 which showed there had been significant improvement. Prescribing practice in relation to these drugs was in normal ranges.

Cleanliness and infection control

The premises were visibly clean and free of clutter. The practice was not responsible for general cleaning as this was arranged for by the management of the Health Centre. Patients we spoke with said they found the premises to be clean and tidy. We checked apparatus such as blood pressure monitors, screens and couches in consultation rooms and found these to be visibly clean. Clinical waste was disposed of in suitable receptacles and used sharp items were kept in sealed containers, out of reach of children.

The practice manager was the infection control lead for the practice. Records showed that infection control audits were carried out annually. The most recent was carried out in February 2014. An action plan was developed following the audit and all points were due to have been achieved by April 2014. One of the action points related to the dating and signing of all sharps bins. During the inspection we noted that the sharps bin in the nurses' room was not dated. We raised this with the practice manager who said this would be addressed immediately. Records showed a Legionella assessment had taken place in 2011.

Staffing and recruitment

We saw that Disclosure and Barring Service (DBS) checks had been carried out on all clinical staff. However, they not been carried out on two non-clinical staff members . Risk assessments had not been carried out to ensure these members of staff were suitable for employment without a DBS check. We also found the system for obtaining references was inconsistent. Not all staff had provided references prior to being employed by the service. Non clinical staff we spoke with said they were either not asked to provide references or could not recall if they had. Staff files we saw were incomplete and therefore we could not ascertain if references were routinely obtained or not.

We looked at records for the most recently employed member of staff (non-clinical). These showed that two references had been provided but only one had been verified. We saw for this member of staff their file did not contain proof of identification. We noted this was the case for at least one other member of staff and their file also did not contain references. There was no evidence that references had been requested and/or received. In relation to the GPs, not all of their files included copies of their GMC registration. It was apparent that the practice did not have a reliable process for ensuring patients were kept safe through its recruitment procedures.

Dealing with Emergencies

The fire alarm was tested once a week and twice a year the evacuation procedure was tested to ensure it was effective. The practice had access to a defibrillator which belonged to the Health Centre. They were not responsible to maintaining and checking it. The practice had purchased a new oxygen cylinder last year which had not yet been used.

The practice had a business continuity plan in place. The document covered a broad spectrum of potential situations that may impact on the ability of the practice to continue its normal business either in the short or long term. This included situations where the building became unavailable for use, loss of computer system/essential data, loss of telephone system and the incapacity of GPs, amongst other situations. The emergency measures detailed in the plan were comprehensive and practical.

Are services safe?

Equipment

The Clinical Commissioning Group (CCG) was responsible for the premises the practice was situated on and they had a maintenance programme in place which included maintenance of the electrics, heating, gas and water supply. We noted there were a number of items that required repairing or replacing. There was a broken chair in the reception area, the button to operate an automatic door for those using a wheelchair was not working and the baby changing unit had been removed. We were told the unit had been broken a week and a half prior to the inspection and so had been removed by the care taker. It had not been replaced.

We saw that patient records were kept in locked cabinets that were not accessible to the public. The reception area was secured by a locked door requiring a security key card to gain access.

Are services effective?

(for example, treatment is effective)

Our findings

The practice was effective. Procedures were in place to ensure care and treatment was delivered in line with appropriate standards. The practice employed qualified and competent staff. Staff training records showed staff received mandatory training relevant to their role. However, because staff had not had appraisals for about three years, there was no formal process to identify training and professional development needs. The practice worked collaboratively with other services to support and enabled multi-disciplinary working. Health information was available to patients and the practice supported patients to live healthier lives.

Promoting best practice

Clinical staff followed National Institute for Health and Care Excellence (NICE) guidelines for example regarding care of patients with cardiovascular disease (CVD) (a disease of the heart or blood vessels) and hypertension (high blood pressure).

We noted a lack of evidence of peer review between the practice's GPs to compare practice and share learning. However the practice participated in a local "practice to practice" peer review process whereby a GP from another local practice visited the practice, reviewed various issues and offered feedback.

Management, monitoring and improving outcomes for people

The practice also compared its outcomes against those of other practices, for example around prescribing practices. The purpose of this was to ensure the practice's prescribing processes were similar to other comparable practices and to identify any anomalies. For example in relation to one drug it was noted that changing to prescribing in tablet rather than liquid form where appropriate could be more beneficial.

The practice participated in the Quality Outcomes Framework (QOF) (a system for the performance management and payment of GPs in the NHS in England, Wales, Scotland and Northern Ireland). The practice monitored its performance in domains including clinical, organisational, additional services and patient experience. We were told participation in this framework helped the practice monitor and manage their outcomes and promote best practice.

Staffing

All staff training records were held on the computer system. They showed staff received mandatory training relevant to their role. However, because no staff had had appraisals for about three years, there was no formal process to identify training and professional development needs. Not all staff records were complete.

Working with other services

The practice worked collaboratively with other services to support and enable multi-disciplinary working. They met with the health visitor every six weeks to discuss children and families and plan their care. The community matron met with the GP on an ad hoc basis. These services were also based within the health centre which supported communication and cooperation between the services. We were told the practice did not have any patients that required palliative care.

Multi-disciplinary meetings took place every six weeks. These meetings were attended by health visitors, clinical staff, social workers and district nurses although we were told district nurses had not been attending lately. The purpose of these meetings was to discuss patients who had been identified as likely to benefit from multi-disciplinary intervention. We saw the minutes of one multi-disciplinary meeting which was specifically to discuss patients with heart failure. This meeting was attended by all of the practice's GPs and a heart failure nurse. Actions from that meeting included improving knowledge of heart failure prescribing and ensuring all patients of the register were being prescribed optimal medication.

The practice received referrals for patients receiving end of life care from local hospitals. They then worked closely with the district nurses to manage those patients care and support them appropriately. Clinicians would also invite the patient in or arrange a home visit to develop a care plan identifying the patient's future wishes and preferences regarding future treatment and whether a power of attorney was in place.

A consultant gynaecologist held a weekly clinic at the health centre and worked closely with the clinicians at the practice. The lead GP met with the local Clinical Commissioning Group (CCG) who were also based in the health centre. The lead GP was part of a CCG

Are services effective?

(for example, treatment is effective)

neighbourhood cluster group. This group was set up was to review performance of the local GP practices, for example around referrals. They considered whether referrals could have been avoided. Action plans were then developed.

Health, promotion and prevention

There was patient information on display in the reception area which provided information about Alzheimer's disease, cancer, drug and alcohol services and weight management. An example of this health promotion information related to a free, eight week weight management programme being held locally. Health education information was displayed about managing minor ailments such as diarrhoea, vomiting, colds and flu. This information was written in plain English and was in an "easy read" format in order to be accessible to a wide range of patients. Information was also available concerning Sickle cell anaemia, a condition that affects mainly Black and Asian populations.

There were leaflets on display inviting those patients who were carers to make themselves known. A carers identification and referral form would be completed to connect carers with local support groups to ensure they received appropriate support.

All new patients were offered screening appointments. A questionnaire was completed which included medical and family histories. These were used to identify any possible risks to the patient's health and as an opportunity to discuss ill health prevention. Patients were also asked about their smoking status and given appropriate advice. Records we saw relating to QOF data showed the practice was performing above target for recording smoking cessation status and advice. The senior partner was trained in smoking cessation and was able to provide appropriate support to those wishing to stop smoking. This included prescribing NHS-endorsed stop smoking aids. There was also a smoking cessation service based within the health centre that patients could be referred to.

Are services caring?

Our findings

The practice was caring. Responses from patients we spoke with and comment cards we received showed that the practice staff treated patients with compassion, dignity and respect. Reception staff were aware of the importance of protecting patient's privacy. All staff described the ethos of the practice as caring and flexible. We noted that staff acted as chaperones although they had not received training to ensure they understood their role and that the service being offered was effective.

Respect, dignity, compassion and empathy

Staff spoke to patients with respect and empathy and listened to their views. We observed a patient speaking to a receptionist about the length of time they had waited to be seen. The receptionist dealt with the patient in a professional and respectful manner and the issue was resolved satisfactorily. Staff meeting minutes showed staff were encouraged to treat patients in a positive and friendly manner. Most of the patients we spoke with said they were treated with respect by all staff although one person said they had had a disagreement with a receptionist and that they had been treated differently since.

Information received prior to the inspection from the GP patient survey showed patients that responded judged the practice to be preforming well in the relevant areas. These included convenience of getting an appointment, privacy and how patients were treated by their GP or nurse. This view was shared by patients we spoke with during the inspection and responses on comment cards we received.

Reception staff were aware of the importance of protecting patient's privacy. For example they took care not to be easily overheard when speaking on the telephone, avoided referring to patient's by name when discussing them at reception and not leaving paperwork in the open at the front desk. One patient stated on a comment card that confidentiality was sometimes compromised at reception due to the open setting but most patients said this was not an issue for them.

The practice did provide a chaperone service and we saw signs on display in the waiting area advertising this. They also had a chaperone policy which staff said they had read. The manager told us non-clinical staff would act as chaperones on request by either the clinician or the patient. We noted that two of these staff had not had DBS checks. We were told this had been considered unnecessary as they were not clinical staff. As these members of staff carried out chaperone duties they may be eligible for such checks. This will need to be reviewed by the practice.

Staff said they would follow the clinician's instructions in terms of what they should do as a chaperone, for example, where they were to stand in the room and what they would be observing. They said they had not received formal training to act as chaperones. We were told that the practice manager had received training about this which had been disseminated to the rest of the staff. We asked but no evidence of this training was provided.

All staff described the ethos of the practice as caring and flexible. The lead GP described how they encouraged other staff not to be too rigid about appointment times and length of the appointment. They told us they did not adopt the "one issue, one appointment" approach and that patients should be treated with consideration and compassion. Practice meeting minutes reflected that this ethos was shared with all staff. Patients we spoke with and responses on comment card we received confirmed this was their experience. Staff were also encouraged to alert patients if clinicians were running late and explain the delay. We observed this being done during our inspection.

Involvement in decisions and consent

Patients were involved in decisions about their care and treatment. Patients were informed before intimate examinations took place and they were allowed to decline if they so wished. Consent decisions were recorded in patient's notes.

Patients we spoke with and responses on comment cards we received reflected that patients were supported to understand their conditions and treatment and were able to ask questions. One patient we spoke with gave an example of an occasion when medication was suggested for their condition but they did not want to take it. The GP discussed natural remedies they could use instead and the patient found these to be helpful.

The lead GP told us in the case of terminally ill patients discussions would be had with the patients and/or with other interested parties about that patient's wishes. Where the patient lacked capacity to make such decisions, discussions would be had with carers and family members/ next of kin to agree decisions in the person's best interests.

Are services caring?

The lead GP said they had attended lectures about the Mental Capacity Act 2005 but had not received any formal training. Formal training about the Mental Capacity Act 2005 could be undertaken by clinical staff to ensure understanding of their role in respect of best interest decisions and to better meet the needs of older patient's, patients with long term conditions (particularly dementia) and those experiencing poor mental health.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice had measures in place to be responsive and meet the needs of its patients, however some improvements could be made. The practice planned and delivered services to meet the needs of different patients. Patients we spoke with and responses on comment cards we received said patients were happy with their care and treatment and felt their needs were being met. The appointment system had recently been reviewed and improved. This review process was on-going. Verbal complaints were not recorded and as such opportunities to improve the service could be missed.

Responding to and meeting people's needs

The practice planned and delivered services to meet the needs of different patients. Patients we spoke with and responses on comment cards we received showed patients were happy with their care and treatment and felt their needs were being met. They said the clinicians understood their conditions and that they were listened to. Annual health checks for patients with learning disabilities were carried out in accordance with the NHS scheme. The service had identified the relevant patients and records showed that all but two had undergone the health check this year. The practice had completed carrying out health checks on those patients aged over 75, also in accordance with the NHS scheme. The practice was in the process of completing health checks for those patients identified as being vulnerable.

A dietician attended the practice once week and received referrals from the clinical staff. The dietician told us staff were proactive in identifying patients who would benefit from their service and that most of the patients who were referred did take up the service. They told us they had worked at the practice for over a year and they had worked together to ensure appropriate referrals were made. The dietician was also able to access information the practice held about patients which helped to ensure a seamless approach to joint working.

The practice had processes in place to ensure patient's needs were met when they moved between services. Information received electronically from other services such as hospitals was saved to the practice's record management system including the date the patient was seen, department and hospital. This information was then passed on to the GPs. This system also alerted staff to tasks such as calling patients back for appointments, prescriptions or tests results.

Childhood immunisations given were logged on the computer system which allowed the practice staff to monitor take up levels and identify where any immunisations had been missed. Reception staff would then contact the parents and invite them to attend a baby clinic or to make an appointment with the nurse. Immunisation records we showed that targets were being met.

Care and treatment for patients with drug and substance misuse issues was available. A drug worker attended the practice once a week to see patients. This session was also open to patients not registered with the practice. Patients were referred to a local charity that worked with those affected by drugs and alcohol. GPs could also prescribe treatments for opiate dependence.

Measures were in place to ensure patients with long term conditions such as diabetes, asthma and cardiovascular disease (CVD) received appropriate and sufficient support. Annual, comprehensive health checks were carried out for patients with asthma and heart disease to monitor their condition and ensure effective management. Regular blood and urine tests were conducted for those patients on a range of drugs for arthritis and bowel problems. A diabetes specialist nurse attended the practice once a week to support patients to manage their condition. Where appropriate patients could be referred to a dietician or podiatrist or to a local diabetes clinic for further treatment. At regular intervals recall searches were carried out by administrative staff to identify patients with long term conditions who were due for their annual review. Staff then called each patient individually to make appointments. Medication for patients on long term medication was reviewed annually. Repeat prescriptions were prescribed for periods of either three or six months at a time depending on the condition.

An interpreting service was available including for sign language. Information about this was on display in the reception area and staff were aware of how to contact them. Patients were not expected to rely on friends or

Are services responsive to people's needs?

(for example, to feedback?)

family to interpret for them. Staff told us interpreters would sometimes attend to assist patients and that this service was used quite widely at the practice. The service also had a hearing loop to assist those with a hearing impairment.

Access to the service

We found the practice was accessible. This was reflected in the results of the GP Patient Survey for 2013 which showed responses regarding appointments and getting through to the serice by telephone as similar to or better than expected. Patients we spoke with during the inspection said they could get through to the practice by telephone although at some busy times they had to hold for a while.

Patients could get appointments either by telephone or in person. At the time of our inspection appointments could not be booked online, nor could prescriptions be ordered online. The practice manager explained that after they had monitored the appointment system over a period of time and consulted with patients, they found that most patients preferred to book appointments for the same day, rather than in advance. As a result the system had been changed and now half of the appointments available each day could be booked in advance and the other half, on the same day. In emergencies patients would be seen the same day. Practice meeting minutes we saw showed reception staff were encouraged to just book patients in in an emergency, rather than waiting to check with a GP first. The practice had also instituted a text service that reminded patients about their appointments. Patients we spoke with and responses on comments cards we received showed that patients found the service accessible and they were able to get appointments at times that suited them. Records showed the practice had managed to reduce the number of wasted appointments and thus improve access to the service.

The practice opened from 8am to 6.30pm Monday to Friday with extended opening hours on Tuesdays (6.30pm to 7.45pm) and Wednesdays (6.30pm to 7.30pm). The practice leaflet and/or website provided information about the opening hours and instructions on how to make appointments, get telephone advice and obtain a home visit. Telephone advice could be obtained by requesting a suitable time to phone to speak to a clinician or by booking a telephone consultation. Home visits were provided for those who were housebound or unable to attend due to their illness. Repeat prescriptions could be ordered in person or by fax or post. Collection was in person or by post. Repeat prescriptions could also be requested electronically through the patient's nominated pharmacy. Usually 48 hours was required for repeat prescriptions, however in an emergency they could be prepared for the same day.

Outside of the practice's normal opening hours patients were directed to the out of hours service. The contact details were provided in the practice leaflet and on the website.

The service was fully accessible to disabled patients with step free access, automatic doors and lifts available.

Concerns and complaints

The practice had an official complaints procedure in place. Leaflets providing information about the complaints process were available at reception. This set out the process for making a complaint, who the complaint should be addressed to and what the practice would do having received the complaint. The leaflet also directed patients to the appropriate authority if they were dissatisfied with the response from the practice. The service provided a leaflet produced by the Parliamentary and Health Service Ombudsman (PHSO) (the organisation that investigates complaints about unfair treatment or poor service from government departments and other public organisations and the NHS in England). This stated that complaints should first be directed to the GP practice before being referred to the PHSO.

The practice manager was responsible for managing complaints. Records showed that complaints received mainly concerned the manner of a previous locum GP. As a result that GP had been advised about their conduct. They were no longer employed by the practice. The practice had two recorded complaints since January 2014. We were told only written complaints were recorded. Verbal complaints were dealt with on the spot by the practice manager but not recorded. This meant there was a risk that opportunities to capture a range of views about the service and to improve the service were missed because there was no record kept of verbal complaints.

Are services well-led?

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

Our findings

The practice was well led with clear and visible leadership and lines of accountability. Governance arrangements were in place and there was effective use of the Patients Reference Group (PRG) to gain patient feedback. There were clear staff values and ethos which focussed on quality. Whilst staff reported feeling valued and well supported, regular supervision and appraisals would provide staff with an opportunity to discuss training needs, speak to the leadership in confidence and to have a structured and measurable approach to their career development. Peer review took place between the practice's GPs and another local GP.

Leadership and culture

The service's Statement of Purpose described their aims and objectives as being a "small, friendly, multi-ethnic practice" and that they "took pride in delivery of the service as a team in a happy, supportive environment". We found that staff understood and shared these values. They all described putting patients first as the practice's main ethos. Staff were aware of the importance of providing a high quality service and described that as a shared purpose. They said the practice had an open and transparent attitude. They were encouraged by the leadership to express their views about the service and to raise any concerns they may have.

Governance arrangements

Lead roles were allocated for different aspects of the business. The lead GP was responsible for information governance and safeguarding at the practice. The practice manager was responsible infection control. Records showed that all staff had received training in information governance.

Systems to monitor and improve quality and improvement

The practice participated in a local "practice to practice" peer review process whereby a GP from another local practice visited the practice, reviewed various issues and offered feedback. We saw records of feedback from a visit that had taken place in August 2013 that related to diabetes. Key actions were agreed following the visit which included identifying patients without a diabetes diagnosis but with high blood glucose levels and making local guidelines more accessible to clinicians during consultations.

Patient experience and involvement

The practice had an active patient reference group (PRG). They communicated by email rather than meeting in person. The practice manager told us this worked better for their patient group as patients found it difficult to find the time to meet in person. We saw a report about the patient survey for 2013/14. This set out the background of the members of the PRG and steps taken to try and improve the representativeness of the group. This document also set out what the PRG had identified as the key areas needing improvement. The patient survey was based around these issues. These issues included the availability of appointments, the ease of getting through to the service by telephone and ease of booking a doctor of your preference.

The 2013/14 survey was given out to 200 patients and 144 responses were received. The results were then collated and evaluated. They were also shared with the PPG for feedback. We saw that an action plan had been put in place as a result of the survey results. These included introducing online appointment booking, improving education about the practice's website and making practice leaflets more readily available. It was stated that a further survey would take place later this year to assess whether improvements in these areas had been made.

Staff engagement and involvement

Practice meetings took place once a month during which the practice was closed and calls were diverted to the out of hours service. We were told clinical staff met regularly on an informal basis. Staff said they were encouraged to speak freely at these meetings and to share any learning points. Staff said they were able to give their views about what could be done to improve the service such as improving the appointments system. They said they felt well supported by the leadership. They described an "open door policy" where staff were able to speak to the practice manager or lead GP when they needed to.

Learning and improvement

At the time of our inspection the practice was in the process of carrying out referral reviews. These involved the GP reviewing referrals and considering if the patients could have been referred other than to hospital. This helped the practice to monitor its referral practice and identify where improvements could have been made. The practice was a

Are services well-led?

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

GP teaching practice and the lead GP supported first and second year medical students. The GP told us being a teaching practice encouraged continuous learning for all clinical staff as well as innovation and improvement.

Identification and management of risk

The senior partner had considered succession options for the practice. They told us they hoped to be able to secure a GP that could be mentored and trained in order to take over the practice in the future. However they told us they had been unable to find such a person so far. We were told this was due to a general shortage of GPs wanting to take on a partnership role. We were told that if they were unable to secure a successor the practice would possibly seek to merge with another local practice.

Older people

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

Our findings

The practice provided a safe, effective, caring responsive and well led service older patients. Processes and procedures were in place to ensure their particular health needs were met. Formal training of clinical staff on the Mental Capacity Act 2005 would help ensure these patients needs are met when the need arises.

The practice provided a safe, caring, effective, responsive and well led service to older patients. The lead GP told us the local population were relatively young and as such they only had a small number of older patients. They had complied with an NHS initiative to allocate each patient aged over 75 a named GP.

We were told the practice had recently signed up to the Facilitating Timely Diagnosis and Support for People with Dementia Enhanced Service. This involved the opportunistic screening of older patients, patients that fell within high risk criteria or patients that had expressed memory problems. The lead GP said they had attended lectures about the Mental Capacity Act 2005 but had not received any formal training. This would help to improve care for older people should the need for best interests decision to be made arise.

District and tissue viability nurses were part of the multi-disciplinary team and attended six weekly meetings. Care and treatment for patients with or at risk of acquiring pressure sores was discussed and planned.

Annual flu vaccinations were provided for patients within this population group. Patients were contacted and reminded to attend. They were also reminded to have their vaccine opportunistically where they had attended the practice for other reasons.

People with long term conditions

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

Our findings

The practice provided a safe, effective, caring, responsive and well led service to patients with long term conditions. Measures were in place to ensure sufficient monitoring and support were available and patients were assisted to manage their own health condition. Where failings were identified, appropriate intervention and referral took place. Formal training of clinical staff on the Mental Capacity Act 2005 would help ensure these patients needs are met when the need arises.

Measures were in place to ensure patients with long term conditions such as diabetes, asthma and cardiovascular disease (CVD) received appropriate and sufficient support. Annual, comprehensive health checks were carried out for patients with asthma and heart disease to monitor their condition and ensure effective management. Regular blood and urine tests were conducted for those patients on a range of long term medication such as for arthritis and bowel problems.

A diabetes specialist nurse attended the practice once a week to support patients to manage their condition. Where appropriate patients could be referred to a dietician or podiatrist or to a local diabetes clinic for further treatment.

At regular intervals recall searches were carried out by administrative staff to identify patients with long term conditions who were due for their annual review. Staff then called each patient individually to make appointments with the nurse. Where it was noted that patient's conditions were being poorly controlled, for example patients with diabetes, patients were referred to a GP or relevant community clinic.

The lead GP said they had attended lectures about the Mental Capacity Act 2005 but had not received any formal training. This would help to improve care for patients with long term conditions should the need for best interests decision to be made arise.

Medication for patients on long term medication was reviewed annually. Repeat prescriptions were prescribed for periods of either three or six months at a time depending on the condition.

Information was also provided for patients with HIV/AIDS and sickle cell disease. The practice had a policy regarding patients diagnosed with HIV/AIDS which highlighted that these patients would be treated in a fair and non-discriminatory way. Information was available about voluntary organisations such as Terence Higgins Trust.

Mothers, babies, children and young people

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

Our findings

The practice provided a safe, effective, caring, responsive and well led service to mothers, babies, children and young people. There were a large number of children registered at the service. Staff recognised and understood the needs of this patient group. Staff had received safeguarding training to help ensure the safety of children. There was effective multi-disciplinary engagement to ensure these patient's needs were met.

The practice carried out both ante and post-natal checks. Mothers were seen by both the GP and the practice nurse. The practice worked closely with the local midwifery team to ensure women received appropriate and effective care and support.

Baby clinics were held once a week at the practice and the lead GP would sometimes run the clinic as well as the practice nurse. Childhood immunisations and six week checks were carried out during the clinics. Childhood immunisations given were logged on the computer system which allowed the practice staff to monitor take up levels and identify where any immunisations had been missed. Reception staff would then contact the parents and invite them to attend a baby clinic or to make an appointment with the nurse. Immunisation records we saw showed that targets were being met.

The health visitor attended every six weeks. Any concerns or news particularly regarding safeguarding issues could be discussed with the health visitor's input. GPs were able to contact paediatric consultants at by telephone when necessary.

The practice ran a cervical screening programme and reminder letters were generated in line with Department of Health guidelines. The practice also offered contraceptive services including intrauterine contraceptive device (IUCD) insertion.

Working age people (and those recently retired)

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

Our findings

The practice provided a safe, effective, caring, and responsive and well led service to patients of working age and those recently retired. The practice had responded to patient feedback and provided more appointments at convenient times to meet the needs of this population group and make the service more accessible to them.

Extended opening hours operated on Tuesdays (6.30pm to 7.45pm) and Wednesdays (6.30pm to 7.30pm) to support those in work to access the service. The practice ran extended hours clinics targeted at patients that work so they did not have to take time off work in order to attend. Same day telephone consultations were available for patients that may not be able to attend.

Following review of the appointment system, half of all appointments were available to be booked for the same day. This met the needs of this population group who may find it more inconvenient to be able to attend appointments booked in advance due to their other commitments.

NHS health checks were offered to patients aged between 40 and 75. Full health checks were also available on request for patients who did not fit this criteria. Flu vaccines were available for those patients within the relevant “at risk” groups.

We saw notices on display advertising activities for patients aged from 40 to 75 to help with weight management.

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

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

Our findings

The practice provided a safe, effective, caring, responsive and well led service to people in vulnerable circumstances who may have poor access to primary care. Homeless people were able to use the practice address to receive mail and thus ensure hospital appointments were not missed. Annual health checks were conducted for patients with a learning disability.

Patients were able to book home visits with the GP if they found it difficult to attend the surgery. The practice was able to request medication deliveries at short notice to patient's home address for patients who were not able to collect their medications.

The practice had a number of patients with a learning disability. They organised annual health checks for patients and we were told the majority did attend. The lead GP told us they took time to explain to patients the importance of attending annual health checks and the overall benefits to their health.

We were told the practice did not have many patients who were known to be homeless. They were aware of a few patients who were in temporary accommodation, such as hostels. The practice allowed homeless people to use the practice address as a "care of" address where this was necessary so that they could receive mail there. This helped to ensure hospital appointments were not missed. The practice would try and liaise with the patient's social worker for a coordinated approach to meeting their needs.

People experiencing poor mental health

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

Our findings

The practice provided a safe, effective, caring, responsive and well led service to patients known to experience poor mental health. A process to ensure regular reviews were carried out was in place. The practice worked collaboratively with the local mental health team and other relevant organisations to ensure patient's needs were met. Formal training of clinical staff on the Mental Capacity Act 2005 would help ensure these patients needs are met when the need arises.

The practice had a process in place for regular reviews of patients known to experience poor mental health. However, they said it was difficult to secure their regular attendance. They tried to address this by contacting patients who had not attended the practice recently by telephone to encourage them to make an appointment and to attend.

The practice did liaise with the local mental health team, however this was not a regular meeting. Meetings were arranged on a patient by patient basis. We were told meetings could be arranged within a couple of days in the case of an emergency.

Patients suffering with depression or anxiety were referred to Improving Access to Psychological Therapies (IAPT) (an NHS programme offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating patients with depression and anxiety disorders). The lead GP showed us the relevant referral form and described the referral process to us. Patients could also refer themselves if they preferred. One patient who had been referred to this service said they found it helpful.

The practice also made referrals using the Assessment and Liaison Service. They provide a single point of referral for patients experiencing a range of mental health problems, potentially avoiding referrals to a secondary mental health services. We were told this service was particularly useful if urgent help was required.

A specific referral service was used for elderly patients suffering from mental health problems.

Once patients had been referred the services would remain in regular contact with the practice and would inform them if the patient was not complying with the service. They would then call the patient to discuss other options. Where patients had been admitted to hospital for treatment, the practice would work closely with the hospital to ensure medication supply was not interrupted.

We were told the lead GP had recently attended a Mental Health Update course to keep up with any new developments. The lead GP had attended lectures about the Mental Capacity Act 2005 but had not received any formal training. This would help to improve care for people with long term conditions should the need for best interests decision to be made arise.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The practice did not operate effective recruitment procedures to ensure those it employed for the purpose of carrying out the regulated activities were of good character.** **Regulation 21(a)(i) and (ii) HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The practice did not have suitable arrangements in place to ensure persons employed for the purposes of carrying on the regulated activities are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to patients safely and to an appropriate standard. Staff acting as chaperones had not received appropriate training to allow them to be effective in this role.** **In addition, because staff had not had appraisals for about three years, there was no formal process to identify training and professional development needs.** **Regulation 23(1)(a) and (b) HSCA 2008 (Regulated Activities) Regulations 2010 Supporting Workers**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

The process for receiving complaints did not include the recording of verbal complaints. Therefore that information relevant to the quality of service provision was not given due regard.

Regulation 10(1)(a) and (b) and 2(b)(i) HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the quality of service provision.