

Dr Kumaran & Partners

Quality Report

Queens Park Medical Practice
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Kumaran & Partners, also known as Queens Park Medical Practice on 6 October 2015. Overall the practice is rated as requires improvement.

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

- Systems were in place to report and record significant events and incidents, however information about safety and lessons learned were not always documented.
- Some risks to patients were assessed and well managed, however improvements were required with those relating to dealing with medical emergencies and managing patients on high risk medicines.
- Most staff had received training appropriate to their roles, although further training relating to infection control and using emergency equipment required planning.

- Patients' needs were assessed and care was planned and mostly delivered following best practice guidance.
- Data showed patient outcomes were average for the locality. Some audits had been carried out to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested, and children were prioritised.
- Most patients said they found it easy to access the service and make an appointment, although some patients commented on waiting for long periods after their appointment time to be seen.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- The practice had a number of policies and procedures to govern activity. Regular practice meetings took place, although minutes and actions from meetings were not always documented.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The areas where the provider must make improvements are:

- Ensure all safety incidents are recorded and reviewed.
- Review the protocols for managing all patients on any high risk medicines.
- Ensure staff receive training in how to use the emergency equipment.

In addition the provider should:

- Review and risk assess what emergency medicines should be kept in the practice.
- Ensure that clinical staff are familiar with the practice's consent policy.
- Ensure the GPs receive infection control training in line with their roles.
- Advertise that a chaperone service and translation services are available to patients on request.
- Formalise the practice's vision and values and ensure staff are made aware of this.
- Maintain a record of decisions and actions arising from practice meetings.

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?

The practice is rated as requires improvement for providing safe services and improvements must be made. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. The practice carried out investigations when things went wrong, however significant events and lessons learned were not consistently recorded. Some risks to patients who used services were assessed and well managed, such as those relating to health and safety and business continuity. However, patients were at risk of harm because some systems and processes were not implemented to keep them safe. For example, we were told there was a shared care protocol for blood monitoring for patients on a particular high risk medicine, however the notes we reviewed suggested weaknesses in how the results of blood tests were reviewed before the medicine was prescribed. The practice kept a limited stock of emergency medicines, however they had not risk assessed the reasons for not keeping a more comprehensive stock. Although emergency equipment was kept, staff had not received training to use the newly purchased defibrillator nor had a date for training been booked.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. There was evidence of completed clinical audit cycles. Staff referred to guidance from the National Institute for Health and Care Excellence 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. Most staff had received training appropriate to their roles and any further training needs had been identified. There was evidence of appraisals and personal development plans for some staff. Arrangements were being made for staff that had yet to receive their annual appraisal. Staff worked with multidisciplinary teams to coordinate patient care.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice similar to or below local and national averages for several aspects of care. The majority of

Good



Summary of findings

patients said they were treated with compassion, dignity and respect. 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?

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 secure improvements to services where these were identified. The practice had good 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. Learning from complaints was shared with staff. Most patients said they found it easy to access the service and make an appointment, although some patients commented on waiting for long periods after their appointment time to be seen.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led. Whilst the GP partners had a vision and strategy for the practice, not all staff were aware of this. There was a clear leadership structure and staff felt supported by management. However, staff were not always aware of who the clinical leads were in areas such as safeguarding and infection control. The practice had a number of policies and procedures to govern activity. Whilst there were some systems in place to monitor and improve quality and identify risk, improvements in dealing with medical emergencies and prescribing high risk medicines were required. We were told monthly team meetings were held, however there was inconsistent evidence of this as some meetings had not been minuted. The practice monitored feedback from patients and staff, which it acted on. There was an active patient participation group who contributed to making improvements to the service.

Requires improvement



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 provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of older people. The practice had a lower percentage of patients over the age of 75 (3.1%) when compared to the national average (7.6%), and patients over the age of 85 (0.8% compared to the national average of 2.2%). The income deprivation level affecting older people was 23 compared to the national average of 22.5.

Nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed. For example, the practice's performance for dementia related indicators in 2013/14 was lower than the CCG and national averages (practice 91.2%; CCG 94.7%; national 93.4%). However, the practice showed us data from 2014/15 which showed they had improved performance for dementia related indicators by achieving 100%.

All patients over the age of 75 had a named GP and were informed of this. The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, which included offering the shingles vaccination and avoiding unplanned admissions to hospital. Monthly multidisciplinary team meetings were used to review care plans and discuss those with enhanced needs. The practice were responsive to the needs of older people, and offered longer appointments, home visits and rapid access appointments for those with enhanced care needs. Patients were reviewed following discharge from hospital and referrals to support services were made to prevent readmissions.

Requires improvement



People with long term conditions

The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of people with long-term conditions. The percentage of patients at the practice with a long standing health condition (37.8%) was lower than the national average (54%). The percentage of patients with health related problems in daily life (38.9%) was also lower than the national average (48.8%).

Requires improvement



Summary of findings

Longer appointments and home visits were available for patients with multiple long-term conditions. The GPs were responsible for chronic disease management. The practice were committed to improving performance and had initiated a dedicated diabetes clinic to improve outcomes for patients. Patients at risk of hospital admission were identified as a priority and had annual reviews to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. For example, the monthly multidisciplinary team meetings were attended by palliative care nurses, and the district nurse. We were told that there was a shared care protocol for blood monitoring for patients on a particular high risk medicine. However, the notes we reviewed suggested weaknesses in how the results of blood tests were reviewed before the medicine was prescribed.

Families, children and young people

The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of families, children and young people. Children aged zero to four represented 8% of the practice population (national average 6.0%); children aged five to 14 represented 14.8% (national average 11.4%); and those aged under 18 years represented 18.4% (national average 14.8%). The income deprivation level affecting children was 33 compared to the national average of 22.5.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Urgent access appointments were available for children who were unwell. Immunisation rates for standard childhood immunisations were comparable to the CCG averages. Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. Appointments were available outside of school hours. Antenatal and postnatal care was provided by the GPs. Targeted screening for young people was also available. For example, young people aged 17 to 18 were offered the meningitis C immunisation, and chlamydia screening was offered to patients aged 16-25 years.

Requires improvement



Working age people (including those recently retired and students)

The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Requires improvement



Summary of findings

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). There was a high percentage of patients between the ages of 25 to 49 years. The number of patients in paid work or full-time education was above the national average, 75.8% compared to 60.2%.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had a website which offered facilities to book appointments and order repeat prescriptions online. Early appointments from 08:00 and late appointments until 20:00 were prioritised for working patients. There was a full range of health promotion and screening that reflected the needs for this age group, including NHS health checks for patients aged 40 to 74. The practice's uptake for the cervical screening programme was 74.2%, which was below the CCG average of 78.6% and national average of 82%.

People whose circumstances may make them vulnerable

The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including housebound patients, carers, those with a learning disability, and patients receiving end of life care. Longer appointments were offered to patients with a learning disability, and these patients were offered an annual health check. Housebound patients and those who could not access the practice were supported via home visits. The practice worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of how to contact relevant agencies in normal working hours and out of hours.

Requires improvement



People experiencing poor mental health (including people with dementia)

The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). In 2013/14 the practice's overall performance for dementia related indicators was above the CCG and national averages (practice 95%;

Requires improvement



Summary of findings

CCG 91.9%; national 90.4%). The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients could be referred to a counselling service, and the practice had access to the community mental health team for more complex or severe mental illness. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing below local and national averages. There were 121 responses which represented 2.28% of the practice population.

- 62% find it easy to get through to this surgery by phone compared with a CCG average of 72% and a national average of 73%.
- 72% find the receptionists at this surgery helpful compared with a CCG average of 83% and a national average of 87%.
- 77% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 80% and a national average of 85%.
- 89% say the last appointment they got was convenient compared with a CCG average of 88% and a national average of 92%.

- 61% describe their experience of making an appointment as good compared with a CCG average of 68% and a national average of 73%.

- 55% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 57% and a national average of 65%.

- 40% feel they don't normally have to wait too long to be seen compared with a CCG average of 74% and national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 61 comment cards which were mostly positive about the standard of care received. Patients said staff always treated them with dignity and respect, and they felt supported in making decisions about their care and treatment.

Areas for improvement

Action the service **MUST** take to improve

- Ensure all safety incidents are recorded and reviewed.
- Review the protocols for managing all patients on any high risk medicines.
- Ensure staff receive training in how to use the emergency equipment.

Action the service **SHOULD** take to improve

- Review and risk assess what emergency medicines should be kept in the practice.

- Ensure that clinical staff are familiar with the practice's consent policy.
- Ensure the GPs receive infection control training in line with their roles.
- Advertise that a chaperone service and translation services are available to patients on request.
- Formalise the practice's vision and values and ensure staff are made aware of this.
- Maintain a record of decisions and actions arising from practice meetings.

Dr Kumaran & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor. The specialist advisor was granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to Dr Kumaran & Partners

Dr Kumaran & Partners, also known as Queens Park Medical Practice, provides GP led primary care services through a Personal Medical Services (PMS) contract to around 5,300 patients living in the surrounding areas of Feltham and Bedfont. (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of NHS Hounslow Clinical Commissioning Group (CCG).

The practice staff comprise of two GP partners (one male and one female); a male salaried GP; a practice nurse; two health care assistant (HCA); a practice manager; and a small team of reception/administrative staff. The GPs collectively cover 19 sessions. The practice nurse works 13 hours per week, and the HCA works ten hours per week. A business manager is employed on an ad-hoc basis.

The practice is located on the third floor of a purpose built health centre, and shares the premises with other health care providers. The premises is accessible by wheelchair.

The practice is open every weekday from 08:00 to 18:30, with the exception of Wednesday afternoon when it closes at 17:00. Extended evening opening hours are available on Monday from 18:30 to 20:00 and on Tuesday from

18:30-19:00. Appointments are offered between 08:30 to 11:00 for morning sessions and 16:00 to 18:00 for evening sessions. Extended hours appointments are offered from 18:00 to 20:00 on Monday, and 18:00 to 19:00 on Tuesday. Appointments can be booked one month in advance over the telephone, online or in person. The practice opted out of providing out-of-hours services to their patients. Outside of normal opening hours and from 17:00 on Wednesday, patients are directed to an out-of-hours GP, or the NHS 111 service.

The practice has a predominantly young population. There is a higher percentage of patients aged zero to four (8%), five to 14 (14.8%), and under 18 (18.4%) when compared to national averages (6.0%, 11.4%, and 14.8% respectively). There is a lower percentage (than the national average) of people with a long standing health condition (37.8% compared to 54%), and a lower percentage of people with health related problems in daily life (38.9% compared to 48.8%). The average male and female life expectancy for the CCG area is 80 for males and 83 for females (national averages 79 and 83 respectively).

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

Why we carried out this inspection

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. The 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

Detailed findings

the service, and to provide a rating for the service under the Care Act 2014. The practice had been inspected in January 2014, however the provider had not been rated before and that was why we included them.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 6 October 2015. During our visit we spoke with a range of staff including: the two GP partners; the practice nurse; the practice manager; the business manager; and three receptionists/administrators. We spoke with eight patients who used the service, including two members of the patient participation group. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 61 comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures.

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.

Are services safe?

Our findings

Safe track record and learning

The practice had a system in place for reporting, recording and monitoring significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. However, we found some examples of significant events had not been documented on the practice's template, and not all actions, reflections and learning points were recorded. An incident book was kept at reception, however this did not show evidence of outcomes or follow-up.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, an incident involving an emergency appointment for a child was discussed. The child was asked to attend an emergency appointment 90 minutes after they presented at the surgery, however their health had deteriorated by the time they saw the GP. The incident was investigated and revealed that the child appeared well when they first presented, however children's breathing can be unpredictable. As a result, the practice changed their policy with regards to emergency appointments for children, whereby children should be asked to wait to be seen rather arranging a later appointment. In addition, a child with a respiratory condition should be seen by any GP in between patients.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements, and policies were accessible to all staff. The policies clearly outlined who

to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding, however this was not universally known by all staff. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3. The GPs told us they did not attend safeguarding meetings with other agencies or provide reports for these meetings.

- A chaperone policy was in place, however we did not see notices advising patients that this service was available. All staff who acted as chaperones had received training for the role and a disclosure and barring check (DBS check). (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A GP partner and the practice manager were the infection control leads. There was an infection control protocol in place. Most staff had received in-house training, with the exception of the GPs. Infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result of the last audit in November 2014. For example, fabric covered chairs in clinical areas were replaced with chairs that were easy to clean and complied with infection control guidelines. The health centre management carried out deep cleaning of the premises every six months.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, handling, storing and security). Medicines audits were carried out with the support of the local CCG pharmacy teams. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccinations.
- The practice had not reviewed protocols for managing patients on high risk medicines such as methotrexate, azathioprine, and sulfasalazine. At the time of

Are services safe?

inspection the GPs were not aware of what the shared care arrangements were with the hospital, and there was ambiguity over who was responsible for the blood monitoring. We immediately made the GPs aware of these safety issues and were assured that the practice would look into this as a matter of urgency. Following the inspection we were told there was a shared care protocol for blood monitoring for patients on the particular high risk medicine. However, the notes we reviewed suggested weaknesses in how the results of blood tests were reviewed before the medicine was prescribed. For example, one patient record we reviewed showed that the GP had increased the medicine dose as recommended by the hospital consultant, however the results from the most recent blood test were not available to view.

- We also found that medicines were not being prescribed in line with alerts from the National Patient Safety Agency (NPSA). For example, good practice prescribing for methotrexate indicated that patients should have the same strength of tablet, however our review of two patient records showed that different strengths were being prescribed. This was permitted under the local CCG's policy, which itself was not aligned to national best practice guidance. The practice had a system in place for reviewing and following-up patients taking anticoagulant medicines such as warfarin.
- We reviewed seven personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The health centre management had carried out a number of risk assessments for the premises. For example, a fire risk assessment had been undertaken in August 2015 and the practice manager told us that the health centre carried out regular fire drills. Staff had received fire safety training, and the practice had two dedicated fire

marshals who had received training to carry out this role. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises, such as legionella.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the GPs and administrative staff to ensure that enough staff were on duty. Locum GPs who were known to the practice were used to cover periods of annual leave or unexpected absences. If the practice nurse was away the GPs would cover some nursing appointments.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the practice.
- The practice had a defibrillator available on the premises and medical oxygen with adult and children's masks. We were told that the defibrillator was newly purchased, however staff had not received training to use the equipment nor had a date for training been scheduled.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. The emergency medicines consisted of those for the treatment of anaphylaxis only, and the practice had not risk assessed why this was or why a more comprehensive selection of emergency medicines were not kept. Staff told us that emergency medicines were checked on a monthly basis, however there were no records to confirm this. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 93.7% of the total number of points available, with 3.9% exception reporting. This was similar to the clinical commissioning group (CCG) average (93.2%) and the national average (93.5%). Data from 2013/14 showed;

- Performance for diabetes related indicators was below the CCG and national averages (practice 78.3%; CCG 83.6%; national 90.1%). Examples of the practice's performance included patients with diabetes who had a blood pressure reading in the preceding 12 months of 150/90 mmHg or less (practice 92.6%, CCG 90.5%, national 91.7%); patients with diabetes with a record of a foot examination and risk classification within the last 12 months (practice 92.7%, CCG 89.1%, national 88.3%); and patients with diabetes who had received the seasonal flu vaccination (practice 86.4%, CCG 92.8%, national 93.4%). We were shown data from the QOF 2014/15, which showed performance for diabetes related indicators had declined to 40%. Staff told us this was mainly due to patients' blood glucose levels not being controlled within the recommended levels. The practice were committed to improving performance and had initiated a dedicated diabetes clinic to improve outcomes for patients. The practice's current performance this year (2015/16) showed they had achieved 45% of the total number of points available so far.

- Performance for hypertension related indicators was above the CCG and national averages (practice 99.6%; CCG 89.7%; national 88.4%). Examples of the practice's performance included patients with hypertension who had a blood pressure reading in the preceding nine months of 150/90 mmHg or less (practice 82.8%, CCG 82.9%, national 83.1%); and patients aged 79 or under with hypertension who had a blood pressure reading in the preceding nine months of 140/90 mmHg or less (practice 80.6%, CCG 75.3%, national 75.3%).
- Performance for mental health related indicators was above the CCG and national averages (practice 95%; CCG 91.9%; national 90.4%). Examples of the practice's performance included patients with schizophrenia, bipolar affective disorder and other psychoses, who had a comprehensive care plan documented (practice 90.9%, CCG 86.4%, national 85.9%); and patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who had a cholesterol blood test in the preceding 12 months (practice 90.9%, CCG 79.4%, national 79.5%).
- Performance for dementia related indicators was below the CCG and national averages (practice 91.2%; CCG 94.7%; national 93.4%). Examples of the practice's performance included patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (practice 88.9%, CCG 88.1%, national 83.8%). However, the practice showed us data from 2014/15 which showed they had improved performance for dementia related indicators by achieving 100%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We were shown five audits completed in the last three years, two of these were completed audits where the improvements made were implemented and monitored. We reviewed an audit on prescribing following an alert from the Medicines and Healthcare products Regulatory Agency (MHRA) regarding cholesterol lowering medicines. The initial audit had been carried out in 2012, and a re-audit took place in 2013. The initial audit showed that 35 patients were on the combination of medicines that required reviewing. Action taken included reviewing these patients and changing the dose of the medicine they were taking, or prescribing another medicine in line with the

Are services effective?

(for example, treatment is effective)

guidelines. The re-audit identified seven patients on the combination of medicines. In addition to the initial criteria, the practice carried out blood tests for these patients prior to initiating a change in medicines.

The practice participated in applicable local audits, benchmarking, peer review and research.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as health and safety, confidentiality, and information governance.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, mentoring, clinical supervision and facilitation and support for the revalidation of doctors. Two members of staff had received their annual appraisal, and we were told that other staff were scheduled to have their appraisal this year.
- Staff received training that included: safeguarding, fire safety, basic life support, infection control, and customer service training. However, we noted that the GPs had not received training in infection prevention and control, and all staff required training on how to use the defibrillator. Staff had access to and made use of online training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. 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 electronically, by post or by fax. Out-of-hours reports, 111 reports and urgent pathology results or letters were seen and actioned the same day. The GP who saw these documents and results was responsible for the action

required. There was a process for reviewing correspondence and staff we spoke with were familiar with this. All relevant information was shared with other services in a timely way, for example electronic systems were in place for making referrals via the 'Referral Facilitation Service'. There was a system in place for sending and monitoring urgent two week wait referrals for conditions such as cancer.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. Vulnerable patients who were discharged from hospital and were at risk of re-admission were routinely contacted for review. Multi-disciplinary team meetings, attended by a district nurses and the palliative care team, took place every two to three months and care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought and the practice had a consent policy which stated a consent form should be used for procedures that carried a degree of risk. However, we noted that only verbal consent was obtained for patients having an intrauterine contraceptive device (IUCD) fitted, and whilst written consent was obtained for minor surgical procedures these forms had not been scanned into patients' medical records. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GPs or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

Are services effective?

(for example, treatment is effective)

Patients were also signposted to relevant services. For example, patients who smoked could be referred to a smoking cessation service within the health centre, and patients who were obese could be referred to a dietician.

The practice's uptake for the cervical screening programme was 74.2%, which was below the CCG average of 78.6% and national average of 82%. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Practice data showed that 96 out of 442 eligible patients had undergone bowel screening, and 368 out of 436 eligible patients had received a mammogram.

Childhood immunisation rates for the vaccinations given were comparable to the CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 82.7% to 94.9% (CCG

78.3% to 92.8%), and five year olds from 74.7% to 95.8% (CCG 61.3% to 91.4%). Flu vaccination rates for the over 65s was 72.07% (national average 73.24%), and at risk groups 63.15% (52.29%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients (HIV screening was carried out if required), and NHS health checks for people aged 40–74. Practice data showed that 67.8% of new patients had received a health check, and 95.2% of patients who were offered the NHS health check had received one. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Targeted screening for young people was also available. For example, young people aged 17 to 18 were offered the meningitis C immunisation, and chlamydia screening was offered to patients aged 16-25 year.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

The eight patients we spoke with, including two members of the patient participation group, provided mostly positive feedback about the service experienced. Patients said they felt the practice offered an excellent service and clinical staff were helpful, caring and treated them with dignity and respect. The 61 CQC comment cards we reviewed highlighted that staff responded compassionately when they needed help and provided support when required. Patients we spoke to and some comment cards provided mixed feedback regarding some reception staff.

Results from the national GP patient survey 2015 showed patients rated the practice lower than local and national averages to questions about how they were treated and if this was with compassion, dignity and respect. For example:

- 67% said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%.
- 64% said the GP gave them enough time compared to the CCG average of 81% and national average of 87%.
- 84% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%.
- 64% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and national average of 85%.
- 78% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 90%.

- 72% said they found the receptionists at the practice helpful compared to the CCG average of 83% and national average of 87%.

The practice told us that they had tried to address poor performance with individual staff members. Feedback from the patient participation group, practice surveys and patients we spoke to on the day did not reflect these views. Patients provided complimentary feedback regarding their interactions with clinical staff.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey 2015 we reviewed showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment, and results were below local and national averages. For example:

- 61% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 86%.
- 59% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 81%.

Staff told us that translation services were available for patients who did not have English as a first language. However, we did not see notices informing patients this service was available. The electronic check-in system had options for patients to view the information in a variety of languages.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The percentage of patients with a caring responsibility was lower than the national average, 13% compared to 18.2%. The practice's computer system alerted GPs if a patient was also a carer and they were supported. For example, carers

Are services caring?

were offered an annual health check, the flu vaccination and referral to support services. A carer's protocol was displayed in the waiting area to ensure carers had written information and understood the various avenues of support available to them.

If a patient had passed away their records were updated immediately. Staff told us that condolence cards were sent

to bereaved patients and they were referred to or given advice on how to access support services. For example, patients could be referred to a counselling service, and information on charitable organisations was available in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice had started planning for the 'out-of-hospital services' whereby additional services such as phlebotomy, spirometry, insulin initiation and ambulant blood pressure monitoring would be offered to patients within the GP practice environment.

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example;

- Longer appointments were available for people with a learning disability, those with mental health conditions, patients receiving palliative care, those with multiple conditions, and for appointments where an interpreter was required.
- Urgent appointments were available the same day for emergencies cases.
- Home visits were available for older patients, those who were housebound, and patients who would benefit from these. These visits were carried out by one of the GP partners.
- The practice offered extended evening hours on Monday until 20:00 and Tuesday until 19:00 for working patients who could not attend during normal opening hours.
- Accessible toilets and baby changing facilities were available.
- Translation services were available. The electronic check-in system had options for patients to view the information in a variety of languages.
- Patients could access a male or female GP.
- Staff told us they tried to be flexible by avoiding booking appointments at busy times for people experiencing poor mental health or who may find this stressful.

Access to the service

The practice was located on the third floor of the health centre and lift access was available for wheelchair users or those with mobility difficulties. The practice was open every weekday from 08:00 to 18:30, with the exception of Wednesday when it closed at 17:00. Extended evening opening hours were available on Monday from 18:30 to 20:00 and on Tuesday from 18:30-19:00. Appointments were offered between 08:30 to 11:00 for morning sessions

and 16:00 to 18:00 for evening sessions. Extended hours appointments were offered from 18:30 to 20:00 on Monday, and 18:30 to 19:00 on Tuesday. Appointments could be booked one month in advance over the telephone, online or in person. Urgent appointments were also available for people that needed them, and information on the appointment system could be found in the practice leaflet and website. Outside of normal opening hours and from 17:00 on Wednesday, patients are directed to an out-of-hours GP, or the NHS 111 service.

Results from the national GP patient survey 2015 showed that patients' satisfaction with how they could access care and treatment was comparable to or below the local and national averages. For example:

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 62% of patients said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 73%.
- 61% of patients described their experience of making an appointment as good compared to the CCG average of 68% and national average of 73%.
- 55% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 57% and national average of 65%.

Feedback from the patient participation group (PPG) showed that patients had commented on the difficulty accessing the practice by telephone. Staff told us they had looked into this matter but it was unresolved at present. In the meantime the practice were trying to promote the use of online services as an alternative for patients contacting the practice for appointments, and using a separate telephone line for calls from the emergency services and other health professionals so that the practice line would not be engaged.

Most of the patients we spoke with were satisfied with the appointments system and said it was easy to use and they could get an appointment when they needed one. Patients confirmed that they could usually see a doctor on the same day and were aware that this might not be with the GP of their choice and that there was usually a wait to be seen. Comment cards we reviewed aligned with these views.

Listening and learning from concerns and complaints

Are services responsive to people's needs? (for example, to feedback?)

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

We saw that information was available to help patients understand the complaints system. For example, information was included in the practice leaflet and on the website. Patients we spoke with were not aware of the process to follow if they wished to make a complaint, however they told us they felt comfortable requesting the information from staff.

The practice received eight complaints in the last 12 months. We reviewed two of these and found these were satisfactorily handled and dealt with in a timely way. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, complaints about staff members were discussed with the individual to prevent reoccurrence and lessons learned were shared at practice meetings.

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 did not have a formalised vision or strategy, and practice values had not been documented or shared with staff. The GP partners were able to describe the practice's vision and strategy for improving services provided for patients and ensuring the service was patient led. They spoke about the 'out-of-hospital services' as a priority for the practice and discussed how these would be incorporated into the practice strategy. Other staff spoke about the importance of providing patient-centred care however they were not aware of a formalised vision or strategy for the practice. We did not see any information on values displayed within the practice.

Governance arrangements

The practice had a governance framework which outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. However, we found that some staff were not aware of who the clinical leads were in areas such as safeguarding and infection control.
- Most staff had received role specific training, however there were gaps. For example, the GPs has not received infection control training and all staff had not received training to use the defibrillator.
- Practice specific policies were implemented and were available to all staff.
- There was a comprehensive understanding of the performance of the practice.
- Clinical audits were used to monitor quality and to make improvements.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, we found that significant events were not documented consistently, there were weaknesses in how the results of blood tests were reviewed before a high risk medicine was prescribed, and the practice had not carried out a risk assessment on what emergency medicines should be kept.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The management encouraged a culture of openness and honesty.

Staff told us that monthly team meetings were held, however there was inconsistent evidence of this as we were told some of these were informal meetings and were not minuted. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so. Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG), national GP patient survey, the friends and family test, a comments box in reception, and complaints received. Results from the friends and family test in September 2015 showed that nine respondents (53%) were extremely likely to recommend the practice and eight (47%) were likely to.

There was an active PPG which met twice a year, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, patients requested more information on health issues and the practice had done this by advertising relevant information such as the seasonal flu and shingles vaccination.

The practice gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The registered person did not have an effective system in place to ensure all significant events and near misses were documented.</p> <p>The registered person had not reviewed the protocols for managing patients on high risk medicines, and there were weaknesses in how the results of blood tests were reviewed before a high risk medicine was prescribed.</p> <p>This was in breach of Regulation 12 (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).</p>