Dr Mohan and Associates

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Mohan and Associates on 13 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, safe and responsive services. It was also good for providing services for the care provided to 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, and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and that they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

There were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- .Ensure water safety through legionella testing
- Ensure the practice business continuity plan is regularly reviewed and updated.

Summary of findings

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice had systems in place to ensure patients were safe including safeguarding and chaperone procedures, and processes to ensure medicines were correctly handled. Patients were treated in a clean environment and processes were in place to monitor infection control. Equipment was fit for purpose and maintained regularly.

Are services effective?

Good

The practice is rated as good for providing an effective service. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was routinely referenced and used by staff. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. However Quality Outcome Framework figures were below the Clinical Commissioning Group (CCG) average. The practice were aware of this and working to improve the figures. Staff received appropriate training for their roles and further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced. The practice was able to demonstrate completed audit cycles where changes had been implemented and improvements made.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others in the locality for several aspects of care. For example 94% of patients that completed the GP Patient Survey 2014 had confidence in the last nurse they spoke with, which was above the Clinical Commissioning Group (CCG) average of 86%. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff

Summary of findings

treated patients with kindness and respect ensuring confidentiality was maintained. The practice had an active Patient Participation Group (PPG) which met regularly to discuss practice concerns and to develop the annual patient survey.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the local Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver a high level of service to patients which was set out in the practice statement of purpose. However this was in need of further development. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures, including infection prevention and control and medicines management, to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active Patient Participation Group (PPG). Staff had received inductions, performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people For example 60.6% of patients had received a flu vaccination. All patients had a named GP and this was recorded within their notes The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice met regularly with the community matron team to discuss the on-going needs of the older patients on the practice register.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For example, the practice had undertaken annual reviews for 65% of patients on the chronic obstructive pulmonary disease (COPD) register. Thirty five percent of patients on the COPD register had a self-management care plan documented in their records. 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. The practice also ran diabetic and heart failure clinics for patients.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice had a dedicated member of staff to manage this. Immunisation rates were relatively high for all standard childhood immunisations. For example the practice vaccinated 81.7% of children with the MMR vaccination. No comparative data was available from the Clinical Commissioning Group (CCG). Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside

of school hours and the premises were suitable for children and babies, this included baby changing facilities. We saw good examples of joint working with midwives and school nurses. Joint working with the community health visiting team was limited due to the availability of the team.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). 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 was proactive in offering online services including online booking of appointments. The practice provided a full range of health promotion and screening that reflects the needs for this age group. Support was given to those working people who became ill through the use of medical certificates and the fit note system.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for eight of the 45 patients on the learning disability register. It offered longer appointments for people with a learning disability and those who required interpreting services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The GP also provided a report for the transition of young people in social services care to adult services.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Seventy eight percent of patients on the mental health register had an agreed care plan. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

The practice advised patients experiencing poor mental health how to access support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) who may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs including dementia.

Summary of findings

What people who use the service say

During our inspection we spoke with four patients at the practice and collected 19 CQC comment cards that had been completed by patients.

Patients we spoke with were happy with the service provided and said that they were treated with respect and well cared for. Patients told us that they were involved in the decision making process regarding their treatment, and were given information about all the treatment options available to help them make their choices. We viewed the national GP patient survey 2014 which showed that:

- 81% of patients said that the nurse was good at involving them in their care.
- 58% said that the GP was good at involving them in their care which was below the Clinical Commissioning Group (CCG) average of 72%.
- 73% of patients said that the GP was good at explaining test results and treatments, which was slightly below the CCG average of 79%.
- 94% of patients had confidence in the last nurse they saw or spoke to, which was the same as the Clinical Commissioning Group (CCG) average of 97%
- 98% said that they had trust in the last nurse that they spoke with, which was above the CCG average of 93%

Patients we spoke with who were receiving ongoing treatment were happy with the way their care was being managed and they told us they were kept informed at all times.

In the latest Patient Participation Group (PPG) survey, 87% rated the overall way they were treated positively.

Areas for improvement

Action the service SHOULD take to improve

- Ensure water safety through legionella testing
- Ensure the practice business continuity plan is regularly reviewed and updated.

Dr Mohan and Associates

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. It included a GP advisor and a practice manager who were granted the same authority to enter Dr Mohan and Associates as the Care Quality Commission (CQC) inspector.

Background to Dr Mohan and Associates

Dr Mohan and Associates is a practice located in the London Borough of Barking and Dagenham. The practice is part of the NHS Barking and Dagenham Clinical Commissioning Group (CCG) which is made up of 40 practices. It currently holds a Personal Medical Service (PMS) contract and provides NHS services to 7982 patients. The practice is a teaching practice.

The practice serves a diverse population with many patients attending where English is not their first language. The practice does not have a large older population (6%) and 22.8% of the population is under the age of 14. The practice is situated within a purpose built health centre which it shares with another GP practice. The practice has lift access to meeting rooms and all consulting rooms are on ground level. Staffing comprised six GP's (three male and three female), a GP registrar, two practice nurses, administrative staff and a practice manager.

The practice is open between 8.00am to 6.30pm on each week day except Thursday when it is open from 8.30am to 1.30pm. The practice is open until 8pm on a Tuesday.

Appointments are available from 9am to 1pm for the morning session and then 4.30pm to 6.30pm in the afternoon. Extended hours appointments are available between 6:30pm and 8pm on a Tuesday.

Telephone consultations, and home visits are also offered. The practice opted out of providing an out of hours service and refers patients to the local out of hours service or the '111' service.

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

The practice provides a range of services including child health and immunisation, minor illness clinic, smoking cessation clinics and clinics for patients with long term conditions. The practice also provides health advice and blood pressure monitoring.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 13 May 2015, as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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

How we carried out this inspection

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

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

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 including Barking and Dagenham Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 13 May 2015. During our visit we spoke with a range of staff including GPs, practice nurse, practice manager and administration staff. We spoke with patients who used the service including representatives of the Patient Participation Group (PPG). We reviewed 19 completed Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice used reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example an incident occurred where a patient was given a prescription with the wrong name printed on it. The system for issuing prescriptions was reviewed and a further checking system was put in place to ensure prescriptions were correct before handing to the patient.

We reviewed five safety records and incident reports recorded between November 2014 and May 2015 and found these were discussed in practice meetings. This showed the practice had managed these consistently over time and could evidence a safe track record over this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held six monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Staff completed significant events forms and sent the completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. For example, we saw evidence of action taken as a result of a Chronic Obstructive Pulmonary Disease (COPD) patient with a rescue pack on repeat prescription which was given by administration staff. The rescue pack should only be given if necessary and was to be prescribed by the GP for each occurrence. The patient was contacted about the error in the prescription and the prescription was changed. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example an alert was issued regarding the prescribing of pregabalin (a medicine used to treat nerve pain). A search of practice records was undertaken but it was found that no patients required the medicines. They also told us alerts were discussed in practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to review risks to vulnerable children, young people and adults. Not all staff had received safeguarding and child protection training but were awaiting a date to undertake this. Clinical staff including nurses had received Level three child protection training and reception staff had received Level one. We asked members of both the clinical and non-clinical team about the training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibility to report any concerns and how to contact the relevant agencies. Contact details were easily accessible within the practice office. The practice had a dedicated GP lead for safeguarding and staff were aware of this and that they could speak to the GP if they had a concern.

A chaperone policy was in place and visible in the waiting area and in consulting rooms. Chaperone training had been undertaken by reception staff who were on the practice chaperone list. All staff understood their responsibilities when acting as chaperones including where to sit during the consultation. The practice had a detailed chaperone policy with guidance to follow. All chaperones had received a Disclosure and Barring Service (DBS) check.

The practice used the required codes on their electronic case management system to ensure that children and young people who were identified as at risk, including those who were looked after or on child protection plans,

were easily identifiable. The practice used a risk stratification tool to highlight vulnerable children and adults that were frequent hospital emergency department attenders. Those patients that were flagged were placed on the practice vulnerable patients list which was reviewed in clinical meetings. The safeguarding lead was aware of vulnerable children and adults. The GP's attended child protection hearings in person or provided a report if unable to attend.

Medicines management

We checked medicines stored in the treatment rooms and within the two medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. This also described the action to take in the event of a potential failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by the practice nurse in line with legal requirements and national guidance. We saw evidence that the practice nurse had received the appropriate training to administer vaccines. The practice nurse was also qualified as a prescriber (a nurse qualified to issue prescriptions to patients).

Prescriptions for high risk medicines such as Methotrexate (used for the treatment of arthritis) were reviewed with patients every three months to ensure there was close monitoring of their use.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescription pad numbers were recorded before placing in printers and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and that cleaning records were kept. Patients told us they always found the practice clean and had no concerns about cleanliness. The practice employed an external cleaning company and we viewed the cleaning log held within the cleaning cupboard. Any concerns regarding cleaning were raised directly with the company by the practice manager. The practice undertook daily spot checks of the cleaning and we saw recorded evidence of the daily checks.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and also received annual updates. We saw evidence that an infection control audit had been carried out by the Primary Care Trust in 2012 and that improvements identified for action had been completed on time. This was followed up by the practice carrying out their own audit in 2014. Minutes of practice meetings showed that the findings of the audits were discussed and an action plan developed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. The policy included spillage management, specimen handling and routine equipment decontamination. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However testing had not been carried out in line with the practice policy. The practice had recently purchased a testing kit and were due to undertake the test.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date (February 2015). A schedule of testing was in place. We saw evidence

of calibration of relevant equipment; for example baby scales, diagnostic set, digital blood pressure monitors, spirometers, thermometers, ultrasound and vaccine fridges. Calibration last took place in February 2015.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff was on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation in their contracts. A locum nurse would be used if there was a lack of adequate cover due to the absence of regular nursing staff. The practice manager maintained a staffing matrix to ensure enough staff were present to cover the practice and to plan for any shortage of staff through sickness, external training or annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Risks that occurred within the practice were discussed within clinical team meetings where an action plan would be established. The plan would then be disseminated to the remainder of the staff team through the practice meeting.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. For example staff gave examples of where patients with a long term illness had presented at the practice and due to their deterioration had been seen as an emergency by the GP. Staff spoke about ensuring that patients with a long term condition were referred to secondary care if it was noticed through their health review that their condition was deteriorating. We viewed minutes of meetings between the practice and the district nurse team that discussed the ongoing care of patients with a long term condition and those on the practice vulnerable patients register.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a life threatening allergic reaction that can develop rapidly) and hypoglycaemia (low blood sugar level). Processes were in place to ensure that emergency medicines were within their expiry date and suitable for use. Emergency medicines were checked on a monthly basis. All the medicines we checked were in date and fit for use. The practice had a contract with an oxygen supply company who automatically came to replace oxygen prior to expiry.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to (for example, contact details of a heating company to contact if the heating system failed). However the plan was last updated in 2008.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. The practice had a fire safety log book and tested the fire alarms on a weekly basis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice used a specific computer system placed on each computer in the practice which uploaded the latest guidelines automatically. We saw minutes of both clinical and practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. Staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. One GP gave an example of where the latest British Hypertension Society guidelines were used to train a new GP registrar.

The GPs told us they lead in specialist clinical areas such as cancer and respiratory medicine. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers and mental health conditions. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

To ensure that patients who may be at a higher risk and needed a more detailed needs assessment were identified, a risk stratification tool was used. The tool identified the top 2% of a particular group, for example patients with a high attendance at accident and emergency (including older patients), long term conditions and those patients with mental health concerns. Best practice guidance would then be used to discuss these issues with patients and provide the most up to date care. The practice had a designated administration lead for the management of unplanned admissions who would liaise between the practice and patient. All unplanned admissions to hospital were reviewed in clinical meetings and we were shown copies of the minutes of the meetings where individual patients were discussed. We viewed care plans for those patients identified and saw how a plan was put in place with the practice to effectively manage their health concerns which included health checks and regular reviews. Patients were referred to local services including the community mental health team for further testing and diagnosis.

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

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles. The practice showed us three clinical audits that had been completed within the last 12 months. Following these clinical audits, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, an audit was undertaken in 2014 into whether patients with sickle cell had received a flu vaccination. Those patients that had not received the flu vaccination were recalled for the vaccination to be given. The results of the audit were discussed within practice meetings.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes

Good

Are services effective?

(for example, treatment is effective)

framework (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit of patients that were prescribed prostate-specific antigen (PSA) which is used in the treatment of cancer. The audit was carried out in 2013 and identified three patients that had not seen the GP despite their raised results. These patients were called in for a review. The audit was repeated in 2014. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local Clinical Commissioning Group (CCG) as a whole against the national average. The latest available QOF data showed that overall the practice was performing below the CCG average (92.7%) and the national average (93.5%) achieving 85.7%. This was a general figure which included all areas that QOF covered (clinical care, how well the practice was organised, patient viewed, amount of extra services offered by the practice). The practice used this information to ensure that they were on target to deliver a good service and to discuss, in both clinical and practice meetings, how service could be improved.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 60.6% of patients over 65 years of age had received a flu vaccination, and 79% of patients with dementia had received a care plan. The practice was not an outlier for any QOF (or other national) clinical targets.

The clinical team was making use of Clinical Commissioning Group (CCG) benchmarking against other practices which included reviewing patient attendance at accident and emergency (A&E). Patients were contacted by the practice if they attended A&E frequently and reminded of the services provided at the practice. Clinical meetings were used to discuss and reflect on how the systems at the practice could be improved to achieve outcomes for patients.

Staff checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that patients had received appointments for all routine health checks for long term conditions such as diabetes and the latest prescribing guidance was being used.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all were to be revalidated by the end of 2015. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example training for the computer system and customer service training.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties (For example, on administration of vaccines and cervical cytology). Those with extended roles for example undertaking asthma reviews and the monitoring of diabetes and chronic obstructive pulmonary disease (COPD) were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified, appropriate action had been taken to manage this.

Working with colleagues and other services

The practice engaged with other health services to ensure a multi-disciplinary approach to the care and treatment of those with complex care issues.

We were informed that the practice had good working relationships with the district nurse and the palliative care team and local mental health teams.

Good

Are services effective?

(for example, treatment is effective)

Blood tests, X ray results, hospital letters, information from out of hour's providers and the 111 service were received by the practice electronically, reviewed by the administration staff and passed to the GP or nurse to take the appropriate action within 48 hours. All staff understood their role and felt that the system in place worked well.

The practice held bi-monthly integrated care service meetings to discuss the needs of complex patients, for example those with long term conditions and children on the at risk register. The meetings were attended by community matrons, district nurses and social workers as necessary. Decisions about care were documented in a record card accessible to all members of staff at the surgery to enable continuity of care. No dedicated palliative care meeting was held, however patients were discussed within the weekly clinical meetings. We reviewed the minutes for the last three meetings where palliative care patients were discussed which provided a patient update and the action that was to be taken.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 85% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us this task using the electronic patient record system, and highlighted the importance of this communication with A&E.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. The system was also used to text test results to patients who signed up for the facility.

The practice used a system of passing a request to the on call GP for approval before faxing to the hospital. Codes were used within the electronic system to record this and monitor the activity.

Consent to care and treatment

Clinical staff at the practice had received training in the Mental Capacity Act 2005 and the Children's and Families Act 2014. This training had been cascaded to non-clinical staff members through the practice meetings. The clinical staff that we spoke with were aware of the key parts of the legislation and were able to demonstrate how it was implemented in practice. For example, staff spoke of the need to ensure appropriate consent for treatment was obtained from a patient with a learning disability. We were shown evidence of care plans which required consent and found that appropriate consent had been received.

All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have legal capacity to consent to medical examination and treatment). We were provided with the practice policy for determining the capacity of patients under 16 to give consent and the procedure for the practice to follow. The practice maintained a list of patients where Gillick competencies were needed to assess consent.

There was a practice policy for documenting consent for specific interventions. For example, for fitting contraceptive devices, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

All new patients were offered a consultation with the practice nurse to discuss the patient's lifestyle and to provide information to help improve their lifestyle. This included healthy eating and exercise leaflets and smoking cessation advice. Chlamydia testing and advice was also offered as part of the initial patient consultation for those patients within the age range for this testing. Sexual health advice was offered to young people and those that may be vulnerable. Patients were signposted to other health

Good

Are services effective?

(for example, treatment is effective)

organisations that could be of service if an issue was identified. The practice also offered a full children's immunisation programme. For example, in 2013, the practice vaccinated 81.7% for the MMR. No comparative CCG data was available. The practice telephoned patients who did not attend for vaccinations as a reminder and to encourage attendance.

The practice shared the care of mothers and children with the community midwives team and the practice nurse to provide antenatal care and support to new parents, including weekly baby clinics which provided baby monitoring and post natal checks. The practice worked in support of school nurses. Support for the families of premature babies was also given. No meetings were undertaken with the health visitors due to the limited availability of the health visiting team in the local area. The practice also operated a register of children at risk or in social services care and GPs attended joint meetings to discuss care. The GP also provided a report for the transition of young people in social services care to adult services. Appointments were available outside school times.

The practice offered annual health checks and advice to all patients with specific checks for those placed on the long term conditions register which included structured annual reviews, diabetes checks and blood pressure monitoring. Chronic obstructive pulmonary disease (COPD) checks were also carried out and included spirometry checks (measuring lung function). The practice had undertaken annual reviews for 65% of patients on the practice COPD register and 35% of patients on the register had a self-management care plan documented on their records. The practice was working on improving this figure by reviewing the need for these during consultations. The reviews included a medicines check to ensure medicines were still relevant to the condition. The practice ran a nurse led diabetic clinic which was identified as a local health concern.

Smoking status was added to patient records and smoking cessation classes were run on an ad hoc basis. The practice identified smokers at registration and offered health advice in the new patient consultation. The practice recorded 460 patients who quit smoking in the last twelve months. The practice proactively monitored patients who may be at risk of developing a long term illness through the practice computer system. These patients were called in on an annual basis for a health check to monitor any developments.

Patients over the age of 75 had a named GP which was recorded within the notes. Fortnightly multidisciplinary team meetings were held with the community matrons to discuss the ongoing needs of older patients.

The practice held a register of patients with poor mental health of which currently 78.5% had an agreed care plan. The practice was in the process of ensuring those remaining received a care plan. The practice provided annual physical health checks to patients on the register along with regular mental health reviews. The practice worked in the advanced care planning for patients with dementia and attended multidisciplinary care reviews to discuss these cases. Each patient on the older persons register received a named GP contact. The practice also attended meetings with the local mental health teams to discuss the case management of patients on the mental health register where the GPs provided regular health reports for the meetings. The practice had the service of an in house consultant psychiatrist who met with the GPs to discuss those on the mental health registers and other vulnerable patients that were known to the practice. The practice referred patients to the local memory service for assessment, the locally run mental health team and local counselling service.

The practice had undertaken eight health checks for the 45 patients on the learning disability register. The practice were aware that the figure was low and had assigned a specific member of staff to support this area of work.

Flu vaccinations were offered to all patients with 60.6% of over 65's and 46.1% of pregnant women receiving the vaccination. The practice undertook an audit of their vaccination figures and identified areas to improve. For example, increasing awareness within the various cultural groups represented at the practice.

The practice had a 73.6% uptake for cervical screening which was higher than the latest CCG average of 73.4% (2012/2013). The practice was promoting the need for this service within the practice and sending reminders to those patients that were due for the screening.

Good

Are services effective?

(for example, treatment is effective)

Health advice leaflets were available within the reception area or direct from the nurse. However leaflets were only available in English. Patients were signposted to other health and voluntary organisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and annual patient survey undertaken by the practice's Patient Participation Group (PPG). The evidence from these sources showed patients were positive about the service they received, that they were listened to by staff and treated with respect. Data from the national GP patient survey (452 surveys were sent out and 131 surveys were returned) showed that 94% of patients had confidence in the last nurse they saw or spoke to, which was above the Clinical Commissioning Group (CCG) average of 86%. The survey also showed that 98% said that they had trust in the last nurse that they spoke with, which was above the CCG average of 93%. In the latest PPG survey, 87% rated the overall way they were treated positively.

Patients completed CQC comment cards to provide us with feedback on the practice. We received nineteen completed cards and the majority were positive about the service experience. Patients commented staff were very efficient and involved them in the planning of their treatment. They also told us that the environment was clean and safe.

We also spoke with four patients on the day of inspection, all of whom were happy with the service provided.

Staff told us that all consultations were carried out in the privacy of the consulting room. Disposable curtains were provided in consulting rooms so that patient dignity was maintained during examinations. We noted that the doors to the consulting rooms were closed during a consultation to increase confidentiality. The practice provided a chaperone for any patient that made a request for one. Information on the chaperone service was on display in the reception area.

We noted that there was a small distance between the waiting area and the reception desk to ensure patients were not overheard at the desk by those waiting for an appointment. A room at the side of the reception desk was a designated area for any patient that wished to talk to a member of staff in private before their consultation.

Staff told us that the practice had a culture of ensuring that patients were treated equally. For example, patients experiencing poor mental health or in vulnerable circumstances were able to access the service without fear of prejudice.

Care planning and involvement in decisions about care and treatment

Patient survey information that we viewed showed patients responded positively to questions about their involvement in the planning of their care. For example:

- 81% of patients said that the nurse was good at involving them in their care. Only
- 58% of patients said that the GP was good at involving them in their care which was below the Clinical Commissioning Group (CCG) average of 72%.
- 73% of patients said that the GP was good at explaining test results and treatments, which was slightly below the CCG average of 79%.

These areas were being addressed by the practice in their own patient survey which provided more positive results, for example 87% rated the way they were treated by the GP positively. The practice was working through an action plan in relation to the findings of the patient surveys in order to improve service.

Patients we spoke with on the day had no concerns over involvement in their treatment. All patients said that they were fully involved in the decision making process and that all the options for treatment were explained to them. They also told us they felt listened to and supported by staff to make an informed decision about the choice of treatment they wished to receive without being rushed. Written and electronic health information was available within the reception area to help patients to understand medical conditions.

Staff told us that translation services were available for patients who did not have English as their first language. Patients were asked by the receptionist if they required a translator and the service was also publicised in reception.

Patient/carer support to cope emotionally with care and treatment

The survey information we viewed showed that people were positive about the emotional support that was provided by the practice. People told us that when they needed emotional support the GP would offer support

Good

Are services caring?

through providing an appropriate referral to another service or by providing information of how they could access relevant support groups and counselling services. Patients were contacted by the GP following discharge from hospital. Local voluntary and patient support groups were publicised in reception. The practice also sent congratulations cards to all new mothers.

The practice had a carer's policy and the practice computer system alerted GPs if a patient was also a carer. Identified carers are invited for a care review with the GP and a flu vaccination if appropriate. We were shown written information signposting carers to support groups. Patients who suffered bereavement were telephoned by the GP and invited to the practice to discuss how staff could be of any help.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice engaged regularly with the Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery. For example it was identified that there was a high need for smoking and alcohol screening services. The practice worked with Public Health England to provide services to respond to these needs.

The practice had also implemented suggestions for improvements following patient participation group (PPG) feedback. This included deployment of an extra member of the reception staff to manage telephone calls at peak times.

The GP was involved in a GP 'hub' to manage emergency appointments if they had all been filled at the practice. This involved a number of GP's providing time in a central location in order to provide extra emergency slots.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the availability of both male and female GP's and the ability for patients to request their choice of GP.

The practice had access to face to face and telephone interpreting services, including those for patients with impaired hearing that could be pre booked for appointments if patients requested to use the service.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice had lift access to the meeting rooms on the first floor. All consultation rooms were on the ground level. Wider doorways were in place to accommodate wheelchairs. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice actively supported patients who have been on long-term sick leave to return to work by the promotion of the 'fit note' scheme and ongoing counselling and support.

Access to the service

The practice was open between 8.00am to 6.30pm on each week day except Thursday when it was open from 8.30am to 1.30pm. The practice was open until 8pm on a Tuesday. Appointments were available from 9am to 1pm for the morning session and then 4.30pm to 6.30pm in the afternoon. Extended hours appointments were available between 6:30pm and 8pm on a Tuesday.

Comprehensive information was available to patients about appointments on the practice website and within the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and for those with long-term conditions or where an interpreter or advocate may be required. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one. Telephone appointments were available each day for patients unable to attend the practice or in need of health advice from a GP. Emergency appointments were available at the end of each session.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in

Good

Are services responsive to people's needs?

(for example, to feedback?)

line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system including posters within the waiting room and information in the practice leaflet and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the two documented complaints received in the last 12 months and found that these were handled appropriately in line with the practice complaints policy.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been documented and acted on. The outcome of complaints was shared in both practice meetings and patient participation group meetings to assess whether any changes in process were needed.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision outlined in their statement of purpose to deliver high quality care and to promote good outcomes for patients. These values were clearly displayed in the waiting areas and in the staff room.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures including medicines management, infection control and referral policy. All the policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a GP lead for infection control however we were told the practice nurse was soon to take over this role. The senior partner was the lead for safeguarding. There was a named GP governance lead who took responsibility to ensure all aspects of governance were working appropriately. Governance was discussed within the clinical meeting and we saw evidence of these discussions. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. This included prescribing audits, pathology request audits and an audit of cancer referrals that was highlighted through a significant event.

The practice had arrangements for identifying, recording and managing risks. The practice did not have a risk log; however risks were discussed within clinical meetings when they arose.

Leadership, openness and transparency

We saw that full staff meetings were held fortnightly. This had recently changed from the monthly meeting to increase cohesiveness within the staff group. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, sickness policy, induction policy, whistleblowing policy and disciplinary procedures which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the annual patient survey, NHS Choices website and through the practice comments book which was open to both patients and staff. We looked at the results of the annual patient survey and 68% of patients agreed that the appointments system could be improved. However patients we spoke with on the day were happy with the system. In response to this, the practice deployed more reception staff to answer the telephone, and worked alongside the Clinical Commissioning Group (CCG) to improve access for patients in an emergency through the setting up of a GP 'hub' to manage this if all emergency appointments had been filled. This involved a number of GP's providing time in a central location in order to provide extra emergency slots.

The practice had an active Patient Participation Group (PPG). The PPG was both a physical group which had been active for one year, and a virtual group, which had been active for five years and met over the internet. The PPG included representatives from all the various population groups. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

Are services well-led?

Good

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

The PPG also discussed the bigger issues surrounding the practice and regularly discussed developments within the local community and the local Clinical Commissioning Group (CCG) and how these impacted on the practice.

The practice had gathered feedback from staff through staff meetings and annual appraisals. Staff told us they felt comfortable giving feedback and discussing any concerns or issues with management. They told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported continued learning and development through training and mentoring. We looked at staff files and found that regular appraisals took place which included a personal development plan. Staff were openly encouraged to advance themselves through training for internal promotions.

The practice had completed reviews of significant events and other incidents and shared the information and outcomes with staff during practice meetings to ensure the practice improved outcomes for patients. For example, following an incident where a patient was issued a COPD rescue pack by the reception team, the correct procedures to be followed was reiterated to all staff and the relevant policies updated.