# The Clarence Medical Centre

## 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 | Requires improvement |
| Are services safe? | **Requires improvement** |
| Are services effective? | **Requires improvement** |
| Are services caring? | **Requires improvement** |
| Are services responsive to people's needs? | **Requires improvement** |
| Are services well-led? | **Requires improvement** |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

**REQUIRES IMPROVEMENT**

We carried out an announced comprehensive inspection at Clarence Medical Centre on 4th November 2014. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective, caring, responsive and well led services. It also required improvement for providing services for the older people, people with long-term conditions, 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). We found the practice was inadequate for providing services to families, children and young people.

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.
- 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.

The areas where the provider should make improvements are:

- Ensure completed clinical audit cycles are under taken in order to evidence that audits were driving improvements in performance to improve patient outcomes.
- The practice should ensure that all staff who are required to chaperone patients receive the appropriate training.

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- The practice should ensure there have a policy for spillage and a mercury spillage kit as per guidance from Public Health England (PHE) as the GP's were using old mercury blood pressure monitors
- The practice should ensure they have formal arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs
- Review and improve the current layout of the waiting room area to ensure patient confidentiality.
- Enable the practice website to allow patients to book appointments online.
- Ensure information is made available to patients to make them aware that the practice do not carry out childhood immunisation on site.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were undertaken and lessons learnt were communicated to all staff. However, administration staff who were required to act as chaperones on occasions had not received chaperone training. The practice did not have formal arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Staff that had recently left had not been replaced and we were told that on occasions this could put a strain on reception staff, as they also had to cover for each other when staff were on holidays.

**Are services effective?**

Requires improvement

The practice is rated as inadequate for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or below average for the locality. Reference to national guidelines was inconsistent. The practice showed us three audits that had been started last year however, there were no completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. The practice met regularly with a health visitor but multidisciplinary working was generally informal and record keeping was limited or absent. We did not see any evidence that the practice used the information they collected for the QOF to monitor or improve outcomes for patients.

**Are services caring?**

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made. Data showed that patients rated the practice lower than others for some aspects of care. Patients said they were treated with compassion, dignity and respect and we received 21 completed comment cards and all were positive about the practice. However not all patients felt listened to. Data showed patients responded not so positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice low in these areas. Only 68%% of practice respondents said the GP involved them in care decisions and 69%

# Summary of findings

said the last nurse they saw or spoke to was good at involving them in decisions about their care. Due to the size and layout of the waiting room conversations could easily be overheard therefore confidential information could not always be kept private.

**Are services responsive to people's needs?**

**Requires improvement**

The practice is rated as requires improvement for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice was equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand and there was evidence that learning from complaints had been shared with staff. The premises were accessible to patients with disabilities and the toilets were accessible to wheelchair users. The practice had extended hours opening one day a week. However, the practice did not hold a register of patients living in vulnerable circumstances except patients with a learning disability. It had carried out annual health checks for people with a learning disability, but there was no evidence that these were structured or had been followed up

**Are services well-led?**

**Requires improvement**

The practice is rated as requires improvement for being well-led. There was a documented leadership structure and most staff felt supported by management and knew who to approach with concerns. The practice had a number of policies and procedures to govern activity and all were up to date. It did not have a vision and a strategy and staff we spoke with were vague about their understanding of the vision and values and were not clear about their responsibilities in relation to these. We were told the practice held monthly governance meetings which were attended by the partners and the practice manager. However, there were no minutes available for us to confirm this.. Although the practice was aware of their QOF scores there was no evidence to demonstrate they used it to improve their performance. The QOF data for this practice showed it was performing below national standards in some areas. The practice did not have any completed clinical audits in the last 12 months. The practice proactively sought feedback from patients and had a patient participation group (PPG). All staff had received inductions and annual performance reviews

# Summary of findings

## The six population groups and what we found

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

**Older people**

Requires improvement

The practice is rated as requires improvement for the care of older people. Patients over 75 years had a named GP to co-ordinate their care. The practice had a list of older people who were housebound whom they would visit regularly. One partner GP carried out home visits to a local care home each week for patients with high nursing care needs, frail elderly patients and elderly patients experiencing poor mental health such as dementia. Longer appointments were available for older people when needed, and this was acknowledged positively in feedback from patients. However, nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed, for example dementia diagnosis and flu vaccinations. The leadership of the practice had started to engage with this patient group to look at further options to improve services for them as the PPG had a sub-group to look specifically at older people's needs.

**People with long term conditions**

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.The practice kept a register of these patients and longer appointments were offered, patients had a named GP and home visits were available when needed. However, not all had personalised care plans and there was no evidence that all had structured annual reviews to check that their health and care needs were being met. The practice did not run any specific clinics for these conditions and data we reviewed prior to our inspection showed the practice were not performing well in relation to the care and management of patients with diabetes. The GP told us they would give opportunistic diabetic care to patients in this group when they attended the surgery.

**Families, children and young people**

Inadequate

The practice is rated as inadequate for the care of families, children and young people. There were no systems in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. However all staff had attended child protection training and were clear about who to contact if they had concerns. The practice did not carry out child immunisations at the practice, patients were sent to the local health centre. However we did not see any information on in the practice leaflet or on the website informing patients of this. The premises were not suitable

# Summary of findings

for children due to its size and layout and we found the heating equipment used on the day of our inspection presented a risk to small children. However practice staff had completed child protection training.

**Working age people (including those recently retired and students)**

**Requires improvement**

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). Although the practice offered extended opening hours for appointments from Monday to Friday, patients could not book appointments online. Health promotion advice was offered and limited accessible health promotion material available through the practice. The practice invited patients over 40 years of age to have an NHS health check but we were told the uptake was relatively low.

**People whose circumstances may make them vulnerable**

**Requires improvement**

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice did not hold a register of vulnerable patients except patients with a learning disability. It had carried out annual health checks for people with a learning disability, but there was no evidence that these were structured or had been followed up. Although the practice met regularly with health visitors they had not worked with multi-disciplinary teams in the case management of vulnerable people. Most staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**People experiencing poor mental health (including people with dementia)**

**Requires improvement**

The practice is rated as require improvement for the care of people experiencing poor mental health (including people with dementia). They had a register for patients experiencing poor mental health and had scored 100% in their QOF results for dementia. It had not worked with multi-disciplinary teams in the case management of people experiencing poor mental health, however they told us they signposted patients experiencing poor mental health to various support groups and voluntary organisations but were not clear as to which ones. It did not have a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. There was no evidence to confirm that people with poor mental health were called for annual physical health checks.

# Summary of findings

## What people who use the service say

We spoke with eight patients during our inspection and received 21 Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were very positive about the practice

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Most of the patients we spoke with had been registered with the practice for many years and told us staff were caring and understanding and the GPs gave good care. However, the findings of the latest national GP patient survey found that 79% of respondents described their overall experience of the practice was good and only 63% said that they would recommend the practice to someone new.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. The patient survey information we reviewed showed patients responded not so positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice low in these areas.

## Areas for improvement

**Action the service SHOULD take to improve**

- Ensure completed clinical audit cycles are undertaken in order to evidence that audits were driving improvement in performance to improve patient outcomes.
- The practice should ensure that all staff who are required to chaperone patients receive the appropriate training.
- The practice should ensure there have a policy for spillage and a mercury spillage kit as per guidance from Public Health England (PHE) as the GP's were using old mercury blood pressure monitors
- The practice should ensure they have formal arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs.
- Review and improve the current layout of the waiting room area to ensure patient confidentiality.
- Enable the practice website to allow patients to book appointments online.

# The Clarence Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

A CQC Lead Inspector. The inspector was accompanied by a GP who was granted the same authority to enter the practice premises as the CQC inspector

## Background to The Clarence Medical Centre

Clarence Medical Centre provides GP primary care services to approximately 1200 people living in Kilburn in the London Borough of Brent. The practice is staffed by two male GPs, one nurse, a practice manager and three administrative staff. The practice held a General Medical Services (GMS) contract and was commissioned by NHSE London. The practice was registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury and maternity and midwifery services.

The practice opening hours were 8.30am to 8pm Mondays and 8.30am to 6.30pm Tuesday to Friday. The out of hours services were provided by an alternative provider. The details of the 'out of hours' service were communicated in a recorded message accessed by calling the practice when it was closed and details could also be found on the practice website. The practice provided health promotion services including a flu vaccination programme and cervical screening.

The national census data stated 18% of the borough's population was white British, 18% white non-British (among which are large, Polish and Irish communities), 8% black Caribbean, 8% black African (amongst which are a large Somalian community) with various other ethnicities (including Indian, Pakistani, Chinese and Sri Lankan) making up the remaining 48%. Around 62% of children under 16 in Brent were classified as living in poverty in 2011, higher than the overall percentage for London (27%) and England (21%). The practice's catchment area of Kilburn has five small areas which fall into the 20% most deprived nationally. None of the wards areas fall into the least deprived nationally.

The CQC intelligent monitoring placed the practice in band one. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

## 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.

## How we carried out this inspection

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

- Is it safe?

# Detailed findings

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

We 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit 4th November 2014. During our visit we spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Requires improvement

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. They had processes in place for documenting and discussing reported incidents and national patient safety alerts, as well as comments and complaints received from patients. Administrative staff and receptionists were encouraged to log any significant event or incident in an incident log book and bring it to the attention of the practice manager. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. We saw they were discussed at the monthly practice meeting. Meeting minutes evidenced that they had discussed an incident where a patient's hospital results were mistakenly given to a family member before the GP had sight of them. The staff team discussed the fact that the report should have been seen by the doctor before it was given to the patient. The learning point noted was that all reports should be seen by the clinicians before a copy was given to the patient.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with told us that alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

**Learning and improvement from safety incidents**

GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. We looked at the significant events from May 2013. Records showed staff were appropriately reporting incidents.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw evidence to confirm that the practice had completed significant event analysis (SEA) annually which included identifying any learning from the incidents. For example we saw a learning point from the above incident was that all reports should be seen by the clinicians before a copy is given to the patient. Staff we spoke with confirmed learning was disseminated to all staff.

**Reliable safety systems and processes including safeguarding**

The practice had up to date child protection and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were available to staff both in paper format and on their computers.

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding children. Clinicians were trained to level 3 and non-clinical staff were trained to level 2. All staff had received adult safeguarding training and the non-clinical staff we spoke with knew how to recognise signs of abuse in older people and vulnerable adults. They were also aware of their responsibilities and knew how to share information of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible on the intranet.

One GP was the lead in safeguarding vulnerable adults and children. They could demonstrate that they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware of who to speak with in the practice if they had a safeguarding concern.

A chaperone policy was in place which was stated in the practice leaflets and signs were visible in consulting rooms. If the nurse staff was not available to act as a chaperone administration staff had been asked to carry out this role. However, we were told that chaperone training had not been undertaken by these staff members although staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff with chaperone duties had been Disclosure and Barring Service (DBS) checked.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

**Medicines management**

Medicines were stored in medicine refrigerators in the nurse's treatment room. There was a clear policy for ensuring medicines were kept at the required

temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily by the nurse to ensure that vaccinations were stored within the correct temperature range. When the nurse was not available the checks were carried out by the practice manager. There was a procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge.

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.

The practice manager was responsible for generating repeat prescriptions. 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 in locked drawers in the nurses office. The GPs reviewed medication for patients on an annual basis or more frequently if necessary.

GPs reviewed their prescribing practices as and when medication alerts were received. We saw from minutes that GPs and the nurse shared latest guidance on medication and prescribing practice at their weekly clinical meetings to keep abreast of updated medication information.

**Cleanliness and infection control**

We observed the premises were clean and tidy. Cleaning records were kept which showed the practice was cleaned daily, and the toilets were checked regularly throughout the day and cleaned when needed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

One GP was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training on infection control specific to their role and received annual updates. We saw evidence that an infection control audit had been carried out in January 2014 by Brent CCG and that any concerns identified had been actioned. For example, we saw that a sharps bin in one surgery was found to be full, however on the day of our visit bins were filled to an appropriate level. Minutes of practice meetings showed that the findings of the infection control audits were discussed.

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. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff told us they would always wear gloves to accept specimens from patients as stated in the infection control policy. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. However we noted there were no hand washing signs displayed in the practice. We raised this with the practice manager who said they would ensure signs are put up immediately.

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). We saw records that confirmed that the practice was carrying out annual checks in line with this policy to reduce the risk of infection to staff and patients.

**Equipment**

The GP's and the nurse told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. However, we noted the blood pressure machine in the waiting room was not working on the day of our inspection. The GP's were using old mercury blood pressure monitors, but we were not shown a policy for spillage or a mercury spillage kit as per the guidance from PHE, where practices use this equipment. 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 which showed tests had been carried out in August 2014. A schedule of testing was in place.

**Staffing and recruitment**

The practice had a recruitment policy in place which was up-to-date. Appropriate pre-employment checks were completed for staff before they started work at the practice. All staff had been in post for a number of years however

staff files for GPs, administrative staff and the nurse contained proof of identification qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

Reception staff told us that although there were enough staff on duty to ensure patients were kept safe, staff that had recently left had not been replaced and staff said on occasions this could put a strain on reception staff, as they also had to cover for each other when staff were on holidays. The practice manager occasionally provided cover in reception during busy periods. The GP partners and practice manager told us they did not have formal arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs.

**Monitoring safety and responding to risk**

The practice had a health and safety policy which staff were required to read as part of their induction which was accessible on the intranet for all staff. The practice manager was the identified health and safety lead and staff we spoke with knew who this was.

The practice had 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, dealing with emergencies and equipment. However, the premises were not suitable for children due to its size and layout and we found the heating equipment used on the day of our inspection presented a risk to small children.

Identified risks were graded as low, moderate, high and discussed at practice meetings. For example a recent risk assessment had identified that security alarm codes were not changed regularly, particularly when staff left the practice. It was therefore agreed that the practice manager would change the code every six months or when staff left the employment of the practice.

The practice had recently developed processes to follow up on hospital referrals for vulnerable patients following an incident where a patient whose health deteriorated significantly as they did not attend the appointment to see a specialist.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Staff records showed all staff had received training in basic life support which was updated every two years. Oxygen was available on site. All staff asked knew the location of this equipment and records we saw confirmed it was checked regularly. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and a risk assessment had not been undertaken.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A Practice Disaster Handling Plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This covered areas such as long or short term loss of access to the building, loss of the computer system, loss of access to paper medical records, loss of the telephone system, incapacity of GPs and loss of water, gas and electricity supply. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and the nurse we spoke with told us they were familiar with current best practice guidance and how to access guidelines from the National Institute for Health and Care Excellence. The GP's attended clinical meetings organised by the CCG in order to stay up to date with the clinical information and guidelines. We saw the practice had monthly clinical meetings where new guidelines were disseminated.

One GP was the lead for specialist clinical areas such as diabetes and chronic obstructive pulmonary disease (COPD). The practice nurses had also attended additional training in the care of patients with diabetes. However, the practice did not run any specific clinics for these conditions and data we reviewed prior to our inspection showed the practice were not performing well in relation to the care and management of patients with diabetes. The GP told us they would give opportunistic care to patients with diabetes when they attended the surgery and were not aware of how they were performing in this area.

Cervical smear and travel vaccinations were provided in-house. Patients were referred to the local health centre for all childhood vaccinations, which was a local arrangement. However we did not see any information in the practice leaflet or on the website to inform patients of this, although one patient we spoke with told us the GP's had told her this. The practice did not have any processes in place to monitor take up of childhood vaccinations.

Practice data showed the practice was in line with referral rates to secondary and other community care services for all conditions. However, there were no processes in place to review whether all referrals were appropriate and/or directed to the correct service.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision making

**Management, monitoring and improving outcomes for people**

The practice had not completed clinical audits within the last 12 months. They showed us two clinical audits that had been started in the last year. These were in relation to Bronchodilators and Warfarin. Although these audits were incomplete we saw that the practice had identified the number of asthmatic patients who had been issued bronchodilator prescriptions over a period of 15 months. Some patients were prescribed as a one off salbutamol inhaler for acute reasons, for example acute wheezy bronchitis and some patients had regular prescriptions. They identified that some patients had not been added to the asthma register as they were not correctly read coded. Although the audit had not been completed the practice were able to demonstrate that one outcome was that all patients with asthma or COPD were now being monitored and called in for regular checks.

Data from the local Clinical Commissioning Group (CCG) of the practice's performance for non-steroidal anti-inflammatory medicines showed the practice was over prescribing in this area. We saw the practice had reviewed all patients on these medications and had altered their prescribing practice, in line with the guidelines and were now performing similar to other practices in the area.

The Quality and Outcome 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) score for 2013/14 was 75.3%, with the practice scoring particularly low in the areas of Chronic Kidney Disease, depression and diabetes at 53%, 56% and 56% respectively. We did not see any evidence that the practice used this information to monitor and improve outcomes for patients. However, the practice scored highly in the areas of Asthma, Dementia and palliative care at 100% for all targets.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GPs prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, recorded the reason why they decided this was necessary.

**Effective staffing**

The practice staff team included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with

Requires improvement

# Are services effective?

## (for example, treatment is effective)

attending mandatory courses such as annual basic life support. One doctor had additional training in the management of diabetes and was able to start patients with type 2 diabetes on insulin. Both GPs were up to date with their yearly continuing professional development requirements and both had a date for revalidation within the next 12 months. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff we spoke with confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a receptionist had been supported to attend a smoking cessation course.

Practice nurses had defined duties they were expected to perform, for example cervical cytology and chlamydia screening. The nurse was able to demonstrate they had appropriate training to fulfil these roles.

**Working with colleagues and other services**

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. All relevant staff were aware of their responsibility in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. One GP would review these documents and results every morning and was responsible for the action required. Staff felt the system in place worked well.

The practice received information from out of hour's providers via fax or secure email and this was checked every morning by one of the GP's.

The practice did not hold multidisciplinary team meetings, however they met monthly with district nurses and decisions about care planning were documented in a shared care record.

**Information sharing**

The practice is shared notes with relevant other providers (such as re palliative care) on a monthly basis.

The practice did not regularly use the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) as staff told us they encountered a number of difficulties with this system and found it easier to arrange hospital appointments manually via the phone, fax or emails. A record of each referral including the sent date was maintained by the administration staff to monitor any delays. Urgent two week referrals for suspected cancer symptoms were faxed and a follow up phone call made after the fax was sent to ensure receipt of referral.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

**Consent to care and treatment**

Clinical staff were aware of the Mental Capacity Act 2005 and their duties in relation to assessing a person's capacity to give consent. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They said patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice kept a register of these patients and when they attended appointments with their carers they would be supported in making decisions about their care which was documented in their care plans.

All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

**Health promotion and prevention**

All new patients who registered with the practice were offered a health check with the practice nurse within a week of registering. The GP was informed of all health concerns detected and these were followed-up in a timely manner. GPs told us they would use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

Cervical screening was offered to woman in line with the national guidelines. The cervical screening uptake rate was approximately 50%for the year 2013 which was similar to other GP practices in the Clinical Commissioning Group (CCG) area. The practice sent text message reminders for patients and would follow up patients who did not attend for cervical smears. The nurse was responsible for following-up patients who did not attend for cervical screening.

The practice offered travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for flu immunisations for vulnerable patients was approximately 45% which was much lower than average for the CCG. The practice stated they were aware of their performance and was continually trying to improve their vaccination take up rates.

Requires improvement

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed staff to be caring, and compassionate towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that they were treated well by the practice and felt respected.

Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback about the practice. We received 21 completed cards and all were positive about the practice. Patients felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent data available for the practice about patient satisfaction from the national GP patient survey from July 2014. The evidence showed patients were satisfied with how they were treated by the GP's and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors as 95% had confidence and trust in the last GP they saw or spoke to. However, 77% of practice respondents said the GP was good at listening to them and 81% said the GP gave them enough time compared to the national average of 80% and 74% respectively.

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

We observed staff tried to follow the practice's confidentiality policy when discussing patients' treatments, however due to the size and layout of the waiting room conversations could easily be overheard, confidential information could not always be kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. Staff told us if patients wanted to speak with reception staff in private they were taken into a side room or up to the practice manager's office, however there was no sign displayed to advise patients of this.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us that any concerns raised would be investigated and any learning identified would be shared with staff.

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients responded not so positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice low in these areas. For example, data from the national GP patient survey from July 2014 showed 68%% of practice respondents said the GP involved them in care decisions and 78%% felt the GP was good at explaining treatment and results compared to the national average of 81% and 84% respectively. Further, and 69% say the last nurse they saw or spoke to was good at involving them in decisions about their care.

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

Staff told us that translation services were available for patients who did not have English as a first language. However, it was very rarely used as the GP's spoke the same languages as the majority of their patients.

**Patient/carer support to cope emotionally with care and treatment**

Notices in the patient waiting room signposted people to a number of support groups and organisations. The

Requires improvement

# Are services caring?

practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

GP's told us they would offer personal support to families who had suffered bereavement by offering a patient consultation at a flexible time and location to meet the family's needs. However, they said they had not signposted any patient to a support service. Patients we spoke with who had had a bereavement confirmed they had received support and said they had found it helpful.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider. The practice liaised with the palliative care nursing team as and when they needed to. Patient deaths were discussed at the monthly practice team meetings.to see if there was any lessons to be learnt.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

Although the practice were aware of the needs of its local population, it had not put in place a plan to secure improvements for the areas identified, for example specifically patients with diabetes who represented a large percentage of the population. The GP's told us the main focus of the practice was to provide routine medical and clinical services.

Patients over 75 years had a named GP to co-ordinate their care. The practice had a list of older people who were housebound whom they would visit regularly. One partner GP carried out home visits to a local care home each week for patients with high nursing care needs, frail elderly patients and elderly patients experiencing poor mental health such as dementia.

The practice had a Patient Participation Group (PPG) who met quarterly. Representatives from this group told us they had a sub-committee to address older people's needs. For example, had produced information of who to contact for support out of hours such as Parkinson's Disease support groups.

The practice had registers for patients who needed palliative care, had complex needs or had long term conditions. We saw patients in these groups would be allocated longer appointment times when needed.

They had a register for patients experiencing poor mental health and had scored 100% in their QOF results for dementia. The GP's told us they could recognise patients who presented in crisis and would contact the community mental health teams for urgent advice if necessary and had referred patients for psychological therapy.

**Tackling inequity and promoting equality**

We were told by staff that a high proportion of the practice population did not speak English as their first language and although they had access a to language line, the GPs spoke most of the relevant languages.

The premises were accessible to patients with disabilities, for example there was a ramp that led to the front door of the practice and the toilets were accessible to wheelchair users.

The practice registered patients who had 'no fixed abode' such as travellers and homeless people. The process for registering would be the same as other patients however 'no fixed abode' would be placed in the address line on the system.

**Access to the service**

The practice was open from 8.30am to 8pm on Mondays and 8.30am to 6.30pm Tuesday to Fridays. The telephones were manned from 8.00am to 6.00pm Mondays to Fridays and a recorded message was available at all other times giving out of hours contact details.. Appointment slots were available throughout the opening hours, except between 12.30 and 1.30 daily, when the practice was closed for lunch. Longer appointments were also available for patients who needed them and those with long-term conditions.

Comprehensive information was available to patients about appointments on the practice website which allowed patients to order repeat prescriptions. Information was displayed in the practice waiting room and on the website directing patients to the NHS 111 out of hour's service when the practice was closed. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hour's service was also provided to patients in the practice information leaflet.

Patients were generally satisfied with the appointments system. Comments received from patients showed that patients in urgent need of treatment were always able to get appointments on the same day of contacting the practice. All patients we spoke with told us they had always been able to get an emergency appointment and if they had not been able to see the doctor the same day, they said they were able to talk with them on the phone.

**Listening and learning from concerns and complaints**

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

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last twelve months and found these were satisfactorily handled and dealt with in a timely way in line with the complaints policy. We saw that when complaints could not be resolved in house or where patients were unhappy with the outcomes, they had been directed to contact the Parliamentary and Health Service Ombudsman.

The practice reviewed complaints on an annual basis to identify any themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. For example where a patient's carer had complained that the practice had not referred their relative for tests in a timely way. The surgery had investigated and found the referral was made, however they implemented a system where there would now follow up on referrals for certain types of test. The practice kept a complaints log and we were told by staff that complaints were regularly discussed and any learning or changes to practice disseminated to all staff.

# 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 clear vision and strategy to deliver high quality care and promote good outcomes for patients. The lead GP's said the vision was to give a good service, good treatment and care and to respond to concerns, however this was not documented anywhere. Staff we spoke with were vague about their understanding of the vision and values and were not clear about their responsibilities in relation to these.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff we spoke with confirmed they had read the key policies such as safeguarding, health and safety and infection control. All seven policies and procedures we looked at had been reviewed annually and were up to date.

We were told the practice held monthly governance meetings which were attended by the partners and the practice manager. They said they discussed performance, quality and risks. However they were no minutes available for us to confirm this.

Although the practice was aware of their QOF scores there was no evidence to demonstrate they used it to improve their performance. The QOF data for this practice showed it was performing below national standards in some areas such as Chronic kidney disease, COPD and diabetes. The practice did not have an action plan improve outcomes in these areas.

The practice did not have any completed clinical audits in the last 12 months. They showed us two clinical audits that had been started in the last year. One audit was aiming to confirm whether patients taking warfarin were compliant with the medication and whether their blood was in the desired international normalisation ratio (INR) range. The GP told us that where they found patients INR was either too low or too high they would make the necessary adjustments to the medication and then would re-audit later this year.

The practice had arrangements for identifying, recording and managing risks. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Environmental risks, such as fire hazards had been discussed at a recent meeting.

**Leadership, openness and transparency**

One of the GP's was the lead for safeguarding and infection control. All members of staff we spoke with were clear about their own roles and responsibilities and knew who the leads for all areas were. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held monthly. 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. They felt they worked well together and that they were aware of their areas of weakness such as the need to improve their flu vaccination take up. Staff said the leadership team were always open to suggestions.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, For example, the recruitment and qualification checking procedure. We were shown the staff handbook which was available to all staff.

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

The practice had a patient participation group (PPG) which met quarterly. The practice told us they recognised the PPG was not representative of the patient group.

The practice used an external company to carry out their patient survey. We looked at the results of the most recent survey which was carried out in 2012 and saw that the practice scored highly in the areas of respect for privacy/ confidentiality and information of services available and scored lower in the areas of waiting times at the practice and complaints and compliments. We saw as a result of this information about services was now available on their website and information leaflets were placed in the waiting room.

Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. They also told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

# Are services well-led?

Requires improvement

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

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy and the process to follow if they had any concerns

**Management lead through learning and improvement**

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. We looked at staff files and saw that annual appraisals were up to date. Appraisals included a personal development plan and staff told us that the practice was very supportive of training.

The practice scheduled meetings for the whole staff team, clinical, non-clinical and operations management monthly. We saw from the minutes of meetings that they discussed where improvements to the service could be made.

The practice had completed reviews of significant events and other incidents and shared learning with staff via meetings to ensure the practice improved outcomes for patients. For example following an incident where a patient with a long term condition had not attended to see a specialist, it was discussed in a practice meeting and a process of following up hospital referrals for patients in this category had been established.