

HHR Medical

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?	Requires improvement		
Are services effective?	Good		
Are services caring?	Good		
Are services responsive to people's needs?	Good		
Are services well-led?	Good		

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at HHR Medical on 25 May 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- In most respects the practice had clearly defined and embedded systems to minimise risks to patient safety. However, we were told that there was no formal system in place for reviewing uncollected prescriptions.
- Prescriptions held in printers were not locked away at the end of the day, though we were told that they were kept in locked rooms which were accessible to contract staff. There was no system in place for monitoring written prescription pads. We found 50

handwritten prescription pads secured in a lockable cupboard. We were told these were rarely used and that there was no system in place for monitoring their use.

- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However the latest available data from the Quality Outcomes Framework (QOF) showed that that the practice were performing below local and national averages in some indicators for the management of patients with diabetes, atrial fibrillation and mental health.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

Summary of findings

- 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.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Ensure that systems and processes are in place for the safe management of medicines; specifically the security and monitoring of prescriptions and for following up patients who have failed to collect their prescriptions.

The areas where the provider should make improvement are:

- Continue with action to improve performance in respect of the management of patients with long term conditions and those experiencing poor mental health.
- Consolidate information in child safeguarding documents into a single policy which is easily accessible to all staff.
- Supply contact information in complaint responses for external organisations patients can escalate complaints to if they are unhappy with the practice's response.
- Promote bowel screening in an effort to encourage uptake.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services.

Requires improvement



- The practice had no system in place for monitoring handwritten prescriptions and the practice did not have a specific policy in place for reviewing uncollected medicines. However, in all other respects the practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Processes for child safeguarding were spread across three separate documents and did not contain information on the practice lead though all staff were aware of the safeguarding leads within the practice. Local safeguarding guidance which contained the information for external contacts was available.
- From the documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework showed outcomes for patients with diabetes, atrial fibrillation and mental health were below average compared to the national average. The practice were aware of this and had taken action to improve the management of these patients.
- Staff were aware of current evidence based guidance.
- We saw evidence that the practice participated in projects which resulted in quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Feedback received from patients on the day of the inspection regarding the quality of care was almost exclusively positive.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example the practice had identified a high proportion of vulnerable children in their practice and had employed a health visitor to ensure that this patient group was supported.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was 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.
- Information about how to complain was available and evidence from the examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as good for being well-led.

Good



Summary of findings

- The practice had a vision and strategy to which aimed to deliver high quality care and promote good outcomes for patients. We saw evidence that the practice had devised strategies for improving clinical targets for the management of long term conditions. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. With the exception of a practice specific policy for safeguarding and reviewing uncollected medicines there were policies and procedures to govern activity and held regular meetings where governance issues were discussed.
- An overarching governance framework supported the delivery of the strategy and good quality care. Although we identified some concerns with the management of medicines within the practice all other risks were adequately reviewed and addressed.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In the examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

Good



- The practice participated in a local CCG initiative providing holistic health assessments for vulnerable older patients either within the practice or in patient's homes. The nurse practitioner or practice nurse undertook a comprehensive assessment of patient's health and social needs followed by engagement with other local health, social and voluntary organisations to ensure that these patients' needs were supported and could maintain their independence where possible. The practice had completed 30 assessments for housebound patients and 37 assessments within the practice.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered onsite phlebotomy to older patients.
- The practice offered proactive, personalised care to meet the needs of the other older patients who did not require a holistic health assessment.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- The practice used a risk tool to identify patients who may need additional support or had complex needs. These patients were discussed in a virtual clinic with a consultant geriatrician to ensure that care and treatment were optimised.

People with long term conditions

As a result of the practice being rated requires improvement for safe and due to the evidence of below average QOF performance for several indicators relating to the management of long term conditions the practice is rated as requires improvement for the care of people with long-term conditions:

Requires improvement



Summary of findings

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Published data indicated that the practice were performing below local and national averages in the management of patients with atrial fibrillation and diabetes. In the case of diabetes the practice attributed their performance to the loss of a practice nurse who was dedicated to the management of diabetic patients. The practice had recruited a new nurse and an additional GP. One of the existing practice nurses had taken on responsibility for the management of diabetic patients in conjunctions with one of the partners. The practice received support from a specialist diabetic nurse working in the community who would overseas practice diabetic clinics and provide mentorship and support to the practice nurse. The practice said that this had resulted in improved compliance amongst their patients and ensured that patients whose condition was difficult to manage were escalated.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice participated in virtual clinics for Respiratory medicine, Heart Failure, and Diabetes for patients whose conditions were complex and typically required secondary care management. Care and treatment for these patients was optimised under the guidance of consultants from secondary care services.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- From the documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.

Good



Summary of findings

- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals. The practice was participating in the Young Persons Friendly initiative and had trained receptionists to provide advice and information regarding local support services.
- The practice would provide support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives to support this population group and held bi-monthly meetings with the community health visitor where child protection issues were discussed. In addition the practice employed an in house health visitor to support the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had processes for managing acutely ill children and young people and for acute pregnancy complications.
- The practice could access advice and support from a consultant paediatrician from a local secondary care facility.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours on Wednesday and evening and weekend appointments through the local extended access hub.
- In response to patient demand the practice had increased capacity for coil and contraceptive implant fittings and provided a cervical screening during their extended access hours on Wednesdays.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice had facilitated two workshops that provided patients with information on how to book appointments online and increased the availability of online booking above their contractual requirement which benefited working age people.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- The practice held a register of patients living in vulnerable circumstances including homeless people, those who have experienced or are at risk from Female Genital Mutilation and those with a learning disability. Practice staff had received training on how to support these vulnerable groups.
- Of the 18 patients the practice had on their learning disability register 16 had received an annual health check.
- The practice recently participated in a study which resulted in all of their patients deemed to be at risk from Hepatitis B and C to be offered screening.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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)

The practice is rated as good for the care of patients experiencing poor mental health conditions (including people with dementia):

Good



- Performance for mental health indicators was lower than local and national averages. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record, in the preceding 12 months was 64% compared with a local average of 85% and a national average of 89% nationally. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a

Summary of findings

record of alcohol consumption in the preceding 12 months was 75% compared with the CCG average of 87% and the national average of 89%. However we reviewed unverified data from 2016/17 which indicated an improvement in these areas.

- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 70% compared with the CCG average of 82% and a national average of 84%. Unverified data from 2016/17 showed that 100% of these patients had their care plan reviewed.
- The practice had an in-house counsellor and hosted a worker from the local talking therapy service.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia both during consultations and when undertaking care reviews under the holistic health assessment scheme.
- Although the practice told us they reviewed uncollected prescriptions every three months there was no formal system in place for dealing with these which could pose a risk to certain patients in this population group.
- The practice held quarterly multi-disciplinary meetings for those with serious mental health needs under a scheme aimed at providing increased mental health support in the community. The practice also participated in a virtual clinic for mental health patients to ensure care and treatment were optimised.
- The care of patients with dementia was also discussed with other agencies.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Three hundred and sixty four survey forms were distributed and 104 were returned. This represented 1.6% of the practice's patient list.

- 88% of patients described the overall experience of this GP practice as good compared with the CCG average of 85% and the national average of 85%.
- 77% of patients described their experience of making an appointment as good compared with the CCG average of 73% and the national average of 72%.

- 79% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 80% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 39 comment cards all but one of which were exclusively positive about the standard of care received. Patients said that staff were friendly and supportive.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring, responded well to their needs and involved the patient in decisions about their care and treatment. All but one patient said that they had easy access to both GP and nursing appointments.

HHR Medical

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and Practice Manager specialist adviser.

Background to HHR Medical

HHR Medical is part of Lambeth Clinical Commissioning Group (CCG) and serves approximately 6500 people. The practice is registered with the CQC for the following regulated activities Diagnostic and Screening Procedures, Treatment of Disease, Disorder or Injury, Maternity and Midwifery Services and Family Planning and Surgical Procedures

The practice population has a larger working age population and smaller proportion of patients over the age of 65 compared to the national average. The ethnicity of the patient list is diverse with 8.2% identifying as mixed, 5.8% as Asian, 35.6% black and 3.2% other non-white ethnic groups. The practice is located in an area which is ranked as the second most deprived decile on the index of multiple deprivation with higher levels of deprivation amongst both older people and children.

The practice is run by two male partners and employs two GPs one male and one female of mixed gender. The practice employs a full time nurse practitioner and two part time nurses. The practice offers 28 GP sessions.

The practice is open between 8.00 am and 6.30 pm Monday to Friday. Appointments are from 8.30 am to 11.20 am Monday to Friday and resume 3.30pm to 6 pm in the evening except on Thursday when surgery resumes at 4pm. Extended surgery hours are offered between 7.30 am and

8.30 am and 6.30 pm to 7.30 pm on Wednesdays. In addition to pre-bookable appointments that can be booked up to one month in advance, urgent appointments are also available for people who need them which can be booked the same day. Patients can also book appointments 24 hours or 48 hours in advance. If patients require treatment at the weekend the practice can refer them to the local GP access hub which provides care from 8am – 8pm seven days a week through the local Federation.

HHR Medical operates from 1-3 Herne Hill Road, Loughborough Junction, London, SE24 0AU which are purpose built premises which are owned by the partnership. The service is accessible for patients with mobility difficulties and has a lift to enable patients to access consulting and treatment rooms on the upper floors.

Practice patients are directed to contact the local out of hour's provider when the surgery is closed.

The practice operates under a Personal Medical Services (PMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These are: extended hours access, learning disabilities health checks, out of area registration, minor surgery and GP delivery scheme.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 25 May 2017. During our visit we:

- Spoke with a range of staff (GPs, Nurse Practitioner, Practice Nurses, Practice Management and reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia).

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

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events and used an electronic system to raise near misses and other events which may involve other healthcare providers so that learning could be shared.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, we reviewed one incident which related to a patient being issued a prescription that was intended for another patient with a similar name. The practice apologised and made sure that the correct prescription was issued and instructed all staff to confirm patients date of birth and name before beginning a consultation or when signing them in at reception. At the annual review of significant events the practice decided that alerts would be placed on receipts of patients with similar sounding names to ensure that this error did not occur again. The practice had also had a power failure a week prior to the inspection which had impacted on the fridge temperatures the vaccines within the practice

were stored at. The practice had reviewed the practice fridge temperatures, checked the viability of the vaccines with the manufacturer and disposed of the effected vaccines.

- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were lead members of staff for child and adult safeguarding. However, child safeguarding information was split across three documents and the name of the practice lead was not mentioned in any of this documentation. Nonetheless, all staff spoken to knew the identity of the practice leads. From the documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level three and reception and administrative staff to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS)

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had

Are services safe?

received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example the audit had identified that a curtain in the treatment room risked coming into contact with a clinical waste bin. The practice mounted a chain which was used to tie back the curtain to prevent contact with the waste bin.

Most of the arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal). However, there was not an effective system in place for monitoring and storing prescriptions or reviewing uncollected medicines.

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms used in printers were kept in locked rooms though these were accessible to contract staff. We found 50 written prescription pads. Though these were securely stored there was no effective system in place to monitor their use. The practice told us that uncollected prescriptions were reviewed approximately every three months but there was no process for action to be taken when a prescription had not been collected. Two of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff and from a local nurse prescriber support group for this extended role. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).

We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence

of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. The most recently recruited staff member did not have a DBS check on file though we saw evidence that this had been requested and the practice had placed appropriate restrictions on their duties until this had been received.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through sample checks of patient records and through new software systems which prompted clinicians with the latest best practice and guidance.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 90% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 95%. The practice's exception reporting rate was 6% compared with the CCG average of 8% and 10% nationally (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was lower than the CCG and national averages. For example the percentage of patients with diabetes who had well controlled blood sugar was 54% compared with a local average of 71% and the national average of 78%. The percentage of patients with well controlled blood pressure was 64% compared with 75% locally and 78% nationally. The practice provided unverified QOF data

for 2016/17 which showed that the number of patients with well controlled blood sugar had increased to 61% and the percentage of those with optimal blood pressure had reduced to 56%.

- Performance for mental health related indicators was lower than the CCG and national averages. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months was 64% compared with a local average of 85% and a national average of 89% nationally. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months was 75% compared with the CCG average of 87% and the national average of 89%. Unverified QOF data for 2016/17 provided by the practice showed that the percentage of patients with care plans had increased to 83% but that the numbers of patients with their alcohol consumption recorded remained the same.

The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 70% compared with the CCG average of 82% and a national average of 84%. Unverified QOF data provided by the practice showed that this had improved and that in 2016/17 100% of these patients had been reviewed.

- The percentage of patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation therapy was 75% compared with a CCG average of 87% and the national average of 87%. We reviewed unverified QOF data for 2016/17 for these patients and found that 71% of eligible patients were being treated with anticoagulation therapy in that year.

One of the partners had leadership responsibility and oversight for QOF performance. They attributed the lower scoring to recent changes in the leadership structure, changes in staffing and the fact that they had been busy providing additional training to the practice nursing staff to facilitate their increased involvement in chronic disease management.

Specifically in the case of diabetes the practice also attributed their performance to the loss of a practice nurse

Are services effective?

(for example, treatment is effective)

who was dedicated to the management of diabetic patients. The practice had recruited a new nurse and an additional GP. One of the existing practice nurses had recently taken on responsibility for the management of diabetic patients in conjunction with one of the partners. The practice received support from a specialist diabetic nurse working in the community who would oversee practice diabetic clinics and provide mentorship and support to the practice nurse. The practice said that this had resulted in improved compliance amongst their patients and ensured that patients whose condition was difficult to manage were escalated.

The practice had tasked a member of the reception team to take responsibility for recalling patients suffering poor mental health. Any patients who did not attend for their appointments were rebooked and the patient's GP would be notified. The practice also participated in the GP plus scheme which provided support to patients with complex mental health problems, who would typically require secondary care management, in the community with the assistance of specialists.

The practice also participated in virtual clinics for patients with diabetes and those with atrial fibrillation which aimed to optimise care and treatment for the most challenging patients with the support of input from secondary care.

The practice told us that they would hold a near year end QOF meeting to review performance and address any areas where they were falling behind.

There was evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, the practice had undertaken an audit to review practice compliance with NICE guidance related to the prescribing of antibiotics for sore throats. The first cycle completed in March 2017 showed compliance of 80% against NICE guidelines. The results of the audit and the importance of adhering to the guidance were discussed in a clinical meeting and when the practice completed a second cycle of the audit compliance had increased to 90%.

- The practice participated in virtual clinics for patients with diabetes, mental health and asthma which aimed to optimise care for patients with these conditions with the support of consultants from secondary care. We were provided with the data for the virtual clinic reviewing patients with asthma. Of the 20 patients reviewed 14 had their treatment optimised in line with current guidelines and best practice. When these patients were subsequently reviewed two patients' conditions had worsened due to smoking and infection. The remainder showed either improvement or no change.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, dementia, learning disabilities and for conducting minor surgery.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings and the local practice nurse forum.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules, in-house training and protected learning events within the CCG.

Are services effective?

(for example, treatment is effective)

- The practice was a training practice for medical students.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the 16 examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. All patients were assessed using a frailty scoring tool upon discharge from hospital to assess the level of support required once they moved back into the community. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals, including district nurses and community matrons, on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Written consent forms were used for minor surgical procedures.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice offered weight management clinics and would refer patients to a dietician if required. Smoking cessation advice was available from the practice nursing staff. The practice also had an in-house health visitor and other agencies offered services on the practice premises including counsellors and a chiropodist.

The practice's uptake for the cervical screening programme was 81%, which was comparable with the CCG average of 78% and the national average of 81%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 91% to 97% and five year olds from 82% to 94%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for breast cancer. However the percentage of those screened for bowel cancer was lower than the local and national average; 37% compared with 43% and 58% respectively. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All but one of the 39 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. The other response did not give detailed feedback.

We spoke with seven patients including one member of the patient participation group (PPG). They all told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Comments highlighted that staff responded compassionately when they needed help and provided support when required; including in respect of the management of long term conditions, assisting with maternity and early child development.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 81% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 78% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.

- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local average of 84% and the national average of 85%.
- 84% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 91%.
- 87% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 96% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 95% and the national average of 97%.
- 82% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local average of 87% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared with the CCG average of 87% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Children and young people were treated in an age-appropriate way and recognised as individuals. We spoke with a mother who said that the practice had always provided excellent care for her children. The clinical staff were able to give examples of how they ensured that children and young were treated appropriate to their age. We were told that younger members of the reception team had been sent on training as part of a new initiative to

Are services caring?

enable them to speak with younger patients who may feel apprehensive speaking to a clinical staff member. Patients could then be referred to clinical staff or other local support services as appropriate.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 73% of patients said the last GP they saw was good at involving them in decisions about their care compared to the local average of 81% and the national average of 82%.
- 84% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 90%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the local average of 82% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

- The Choose and Book service was used with patients as appropriate. (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).

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services. Elderly patients who were housebound patients or those who may feel isolated would be assessed by the nurse practitioner.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 92 patients as carers (1.4% of the practice list). There was lots of information available for carers in different areas of the waiting area which would direct those with caring responsibilities to various avenues of support available to them. The health promotional screen in the reception area showed a video which encouraged patients to seek assistance. Older carers were offered timely and appropriate support.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy letter which contained information on how to find a support service. There was lots of information available in the reception and waiting area which directed bereaved patients to local support services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population: For example the practice had identified a high proportion of vulnerable children in their practice and had employed a health visitor to ensure that this patient group was supported.

- The practice offered extended hours on Wednesday from 7.30 am until 7.30pm for working patients who could not attend during normal opening hours. In response to patient demand the practice had increased capacity for coil and contraceptive implant fittings and provided a cervical screening during their extended access hour's provision.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice had a lift to ensure consulting and treatment rooms on the upper floors were accessible.
- The practice was participating in the Young Persons Friendly initiative and had trained receptionists to provide advice and information regarding local support services.
- The practice provided counselling services and hosted a worker from the local talking therapy service. In addition

the practice participated in the GP plus scheme which enabled the practice to provide greater care and support in the community for those patients who would typically require management in secondary care.

- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Access to the service

The practice was open between 8.00 am and 6.30 pm Monday to Friday. Appointments were from 8.30 am to 11.20 am Monday to Friday and resume 3.30pm to 6 pm in the evening except on Thursday when surgery resumed at 4pm. Extended surgery hours were offered between 7.30 am and 8.30 am and 6.30pm to 7.30pm on Wednesdays. In addition to pre-bookable appointments that can be booked up to one month in advance, urgent appointments are also available for people who need them which can be booked the same day. Patients could also book appointments 24 hours or 48 hours in advance. If patients required treatment at the weekend the practice could refer them to the local GP access hub operated by the local federation which provided care from 8am – 8pm seven days a week.

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

- 78% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 76%.
- 77% of patients said they could get through easily to the practice by phone compared to the local average of 78% and the national average of 73%.
- 81% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 82% and the national average of 85%.
- 93% of patients said their last appointment was convenient compared with the CCG average of 89% and the national average of 92%.
- 77% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 66% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 53% and the national average of 58%.

Are services responsive to people's needs?

(for example, to feedback?)

Patients told us on the day of the inspection that they were able to get appointments when they needed them and that access was good.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- The urgency of the need for medical attention.

Cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

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

- We saw that information was available to help patients understand the complaints system. For example all clinicians had a slip patients could fill out available in their room, there were notices in the practice reception area and the information was contained in the practice's patient information booklet.

We looked at four complaints received in the last 12 months and found these were dealt with in a timely manner and comprehensive responses were provided. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, one complaint we reviewed related to a delay in a GP referring a patient to a community health service. Staff were reminded of the protocol for managing referrals in a practice meeting. However, we noted that responses we reviewed did not always contain information about other organisations that patients could contact if they were dissatisfied with the practice's response.

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 developed a vision and strategy which aimed to deliver high quality care and promote good outcomes for patients; including measures to address below average performance for the management of patients with long term conditions and mental health conditions.

- Staff knew and understood the aims objectives and values of the practice.
- The practice had a clear strategy and supporting business plans, drafted for a proposed extension to the premises, which reflected the vision and values.

Governance arrangements

Overall the practice had an overarching governance framework which aimed to support the delivery of the strategy and good quality care; including improving the management of those patients with long term conditions and mental health concerns. However, we saw that the policy for child safeguarding was not easily accessible in a single practice specific document and there were not adequate systems to manage prescription pads and uncollected prescriptions:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. The practice had identified that their performance for the management of patients with diabetes, atrial fibrillation and mental health was below local and national averages and had taken action to improve performance including designating staff as leads in certain areas, seeking support of specialist agencies and participating in virtual clinics. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- The practice undertook activities to monitor quality and to make improvements including audits.
- Most risks were assessed and well managed. However, the practice did not secure prescriptions kept in printers

or have systems in place for monitoring paper prescriptions. We also found that there was no mechanism to review or take action in respect of uncollected prescriptions which could have led to patient harm.

- We saw evidence from minutes of meetings where lessons to be learned and shared following significant events and complaints. The practice undertook annual reviews of significant events and complaints to ensure that any learning derived from either had been implemented.

Leadership and culture

Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held annually. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Good 

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, one patient had given feedback as part of a practice survey stating that they did not like the fact that they were required to check in for their appointment using the electronic screen. The practice always retained the option to check in using both the electronic screen or by speaking to a receptionist. The practice put up signs to notify patients that both methods of checking in were available.
- feedback from the NHS Friends and Family test, complaints and compliments received
- Staff through annual staff away days and generally through staff meetings, appraisals and discussion. Staff

told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management or submit ideas for improvement in the practice. For example the nurse practitioner we spoke with told us that as clinical staff had been on occasion reluctant to prescribe hormone replacement therapy to menopausal women due to the potentially negative side effects. As a result they had suggested hosting a consultant nurse specialist in gynaecology who could provide information and advice to enable clinicians to offer better support to these women. We were told that the practice manager had subsequently invited the nurse specialist to return to the practice to provide a similar talk to patients. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the practice had participated in studies related to rheumatoid arthritis, irritable bowel syndrome and lung health.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Family planning services	Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance
Maternity and midwifery services	How the regulation was not being met:
Surgical procedures	Governance systems and processes were not in place to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk including staff. Specifically in respect of arrangements to secure and monitor prescriptions and to review medicines that patients had failed to collect.
Treatment of disease, disorder or injury	This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.