Henley Cross Medical Practice

Quality Report

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Date of inspection visit: 09 December 2014
Date of publication: 30/04/2015

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Henley Cross Medical Practice on 09 December 2014. We visited the practice site at 115 Tudway Road, Kidbrooke Village. London. SE3 9YX.

The practice has a branch surgery at 444-446 Rochester Way, Eltham. London. SE9 6LJ. We did not inspect the branch surgery location.

Overall the practice is rated as requires improvement. Specifically, we found the practice to require improvement for providing safe, effective and well led services. We found the practice good at providing caring and responsive services. It was good at providing services for all the population groups we report on, with the exception of people with long term conditions where it requires improvement.

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice was run by a long serving staff team, who felt well supported and were committed to their roles.

However, there were also areas of practice where the provider needs to make improvements.

Importantly the provider must:

- ensure that written job descriptions are put in place for the staff team. This had been raised and requested by members of staff during their appraisal meetings
- ensure they have a clear policy regarding which staff members would be subject to Disclosure and Barring Service (DBS) checks, and that their recruitment policy is followed in the recruitment of new staff

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- improve their arrangements to manage medical emergencies by ensuring recommended equipment and medicines used in the treatment of patients in medical emergencies is available or they undertake a risk assessment if a decision is made to not have these medicines and equipment on site.
- ensure that clear summaries of findings, lessons learnt, actions taken and second cycles of clinical audits are completed.

In addition the provider should:

- consider making arrangements to provide greater privacy in the reception area, as face to face and telephone enquiries were responded to by the same staff, all located at the front desk.
- ensure medicines fridge temperatures are checked in line with published guidelines.
- ensure appropriate guidelines are in place for escalating concerning results found during new patient health checks.
- ensure the gaps in the training of staff in safeguarding adults from abuse are addressed.
- ensure suitable records are kept of multidisciplinary working and meetings so that patients are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them
- act on feedback from staff and from the review of patient survey results

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. Lessons were learned and communicated among the staff team to support improvement.

There were enough staff to keep patients safe.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Systems and processes that needed improvement or to be properly implemented included the recruitment procedures, medicines management and the arrangements for dealing with medical emergencies.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

However, data showed the practice performance was worse than the local area and national averages against indicators linked to patient outcomes.

There were no completed audits of patient outcomes made available to us. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but the record keeping was limited.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice well for several aspects of care.

Summary of findings

Patients we spoke with told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand.

We saw that staff treated patients with kindness and respect, and maintained confidentiality.

However, the practice telephone lines were located at the reception desk so telephone conversations could be overheard by people in the waiting area. The practice team should consider making arrangements to provide greater privacy in the reception area, as face to face and telephone enquiries were responded to by the same staff, all located at the front desk.

Are services responsive to people's needs?

Good

The practice is rated as good 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 had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

There was learning from complaints with staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. Staff were clear about the vision and their responsibilities in relation to the practice values. There was a clear leadership structure and staff felt supported by management.

The practice had a number of policies and procedures to govern although we found instances when these were not properly followed such as with the recruitment procedures and staff appraisals. There were systems in place to monitor and improve quality and identify risk.

The practice sought feedback from staff and reviewed the results of patient surveys, but these were not consistently acted upon. The patient participation group (PPG) was not active at the time of our inspection due to a reduction in PPG members as patients had moved away from the area. Staff had received inductions, regular performance reviews and attended staff meetings and events; but we found staff feedback at appraisals were not well followed up.

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 maintained a register of housebound patients, many of whom were elderly. This register was referred to in the planning of the annual flu vaccination campaign, and all patients over the age of 75 were offered seasonal flu vaccinations. The practice had provided seasonal flu vaccination to 64% of its patients over the age of 75, at the time of our inspection, and with ongoing communication via letters and leaflets, and the reception staff providing telephone invitations, they were confident of achieving the target rate of 75% of this group receiving the vaccine in the year ending 31 March 2015.

The patient records of housebound patients were coded so that when they were accessed by the staff, it was flagged that they were housebound so that the most appropriate course of care was offered to them.

Patients requiring home visits were advised to telephone the practice in the morning. The administrative team presented the house call requests to the GP at the end of morning surgery and the GP telephoned them to decide on the best course of action.

Appointments were normally ten minutes long, but longer appointments were available for patients if they had that need.

The practice provided the direct enhanced service (DES) for unplanned admissions. The service was intended to proactively case manage at-risk patients, and required at least 2% of the practice population over 18 years of age to be included in this group. At the time of our inspection, there were 60 patients receiving additional care and support as part of the unplanned admissions DES. Patients in this group received annual reviews and we saw records indicating that they had care plans prepared with their involvement. The clinical staff told us that patients in this group were often offered reviews opportunistically as part of other appointments, to ensure their broader care and treatment needs were addressed.

The practice held clinical meetings, attended by the doctors, nurse and healthcare assistant. The meetings were also attended by other practitioners involved in the care of their patients, such as district nurses and members of the local palliative care team. At these meetings the care, progress and patient outcomes were discussed for specific and complex cases.

Summary of findings

The practice is rated as requires improvement for the care of older people. We found the practice to require improvement for providing safe and effective services, and for being well-led, and that these findings affect people in this population group.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

Patients with long term conditions were treated in routine consultations with doctors and nurses.

Longer appointments and home visits were available when needed.

All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (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). The latest published QOF data for this practice at the time of our inspection, for the year 2013 / 14, showed that overall it performed below the local area and national averages achieving an overall score of 74.9% which was 14.6 percentage points below CCG average, 18.6 percentage points below England average. For particular conditions including Dementia, Diabetes, Hypertension, and primary prevention of cardiovascular disease, the practice performance in the care of patients in these groups needed to be improved.

Families, children and young people

Requires improvement

The practice maintained a list of seriously ill children, and worked with their local pharmacy to coordinate their care and manage their medicines.

The practice had put arrangements in place to obtain information and update the records of pregnant women and their antenatal care. A weekly antenatal clinical was held in the practice on Thursday morning, and was run by the community midwives.

Specific health promotion programmes were in place for women, in line with national guidelines. For example, 77% of women aged

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between 25 and 64 whose notes had record that a cervical screening test has been performed for them in the preceding 5 years; this result was the same as the CCG average and 0.1% above the England average.

Staff in the practice were trained to recognise and respond to signs of abuse in children. The administrative team had completed courses in child protection to level two, and the clinical team to level three. There was a practice statement in place that highlighted to their protocols for dealing with suspected cases of child abuse. This included details of key contacts that the matter would be escalated to within and outside of the organisation, and the responsibilities of the designated lead for child protection in the practice.

The practice is rated as requires improvement for the care of families, children and young people. We found the practice to require improvement for providing safe and effective services, and for being well-led, and that these findings affect people in this population group.

Working age people (including those recently retired and students)

Requires improvement

As of August 2014, 500 patients were of working age in the practice population.

The practice was able to refer patients between the ages of 40 and 74 for NHS health checks at local outreach services. The practice also managed the administration of this checks for their registered patients.

The practice administration team offered a text reminder service for appointments. Patients were also able to cancel their appointments remotely through an automated cancellation service.

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). We found the practice to require improvement for providing safe and effective services, and for being well-led, and that these findings affect people in this population group.

People whose circumstances may make them vulnerable

Requires improvement

The practice maintained a register of patients living in vulnerable circumstances including people who needed treatment as a result of substance misuse substance, and those with a learning disability. It offered longer appointments for people with a learning disability.

Patients who needed additional treatment and support as a result of substance misuse were referred to specialist services. The practice staff told us they had seen a real reduction in the numbers

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of patients needing the substance misuse treatment services since the regeneration of the local area. One of the changes they had made as a result was to stop being a methadone prescribing practice, as the result of the reduction in demand for this service.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However we saw there were gaps in the training of staff in safeguarding adults from abuse.

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. We found the practice to require improvement for providing safe and effective services, and for being well-led, and that these findings affect people in this population group.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice maintained good working relationship with the local (Greenwich) mental health service, which offered a range of services in acute and community settings for adults and children.

The mental health service offered 'Time to Talk', which is part of a national programme to Improve Access to Psychological Therapies (IAPT). The programme is for people with mild problems of anxiety or depression who are motivated to work to change the problem. Patients were able to access the Time to Talk programme through GP or self-referral.

The practice nurse was a trained mental health nurse. The practice was performing well against certain indicators related to the care of patients experiencing poor mental health. For example, 92.7% of patients with physical and/or mental health conditions had a record in their notes of their smoking status in the preceding 12 months; the national average was 95.3%. 94.6% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their record, in the preceding 12 months; the national average was 86.1%. 73% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of alcohol consumption in the preceding 12 months; the national average was 88.6%.

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The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had 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.

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). We found the practice to require improvement for providing safe and effective services, and for being well-led, and that these findings affect people in this population group.

Summary of findings

What people who use the service say

We received six completed comments cards from patients using the practice, all of which were positive and complimentary about the care and treatment provided, and the staff team. Patients complimented the staff team on their friendly manner and their abilities to put them at ease at their appointments.

The results of the latest national GP patient survey at the time of our inspection (published July 2014) showed that patients felt the practice was performing well in key aspects of the service. For example, 85% of respondents described their overall experiences of the surgery as fairly good or better.

We spoke with three patients during our inspection. They told us they received good care at the practice, and that they were treated with respect and dignity. One patient with a long term condition told us they had regular checks and monitoring of their condition, and that the outcomes of referral appointments was followed up with them. The patients we spoke with told us the reception staff were helpful and that they found it easy to get appointments when they needed them.

Areas for improvement

Action the service MUST take to improve

- ensure that written job descriptions are put in place for the staff team. This had been raised and requested by members of staff during their appraisal meetings
- ensure they have a clear policy regarding which staff members would be subject to Disclosure and Barring Service (DBS) checks, and that their recruitment policy is followed in the recruitment of new staff
- improve their arrangements to manage medical emergencies by ensuring recommended equipment and medicines used in the treatment of patients in medical emergencies is available or they undertake a risk assessment if a decision is made to not have these medicines and equipment on site.
- ensure that clear summaries of findings, lessons learnt, actions taken and second cycles of clinical audits are completed.

Action the service SHOULD take to improve

- consider making arrangements to provide greater privacy in the reception area, as face to face and telephone enquiries were responded to by the same staff, all located at the front desk.
- ensure medicines fridge temperatures are checked in line with published guidelines.
- ensure appropriate guidelines are in place for escalating concerning results found during new patient health checks.
- ensure the gaps in the training of staff in safeguarding adults from abuse are addressed.
- ensure suitable records are kept of multidisciplinary working and meetings so that patients are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them
- act on feedback from staff and from the review of patient survey results

Henley Cross Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The other member of the team was a GP specialist advisor. Experts and advisors that we use on inspections are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Henley Cross Medical Practice

Henley Cross Medical Practice is a GP practice in the London Borough of Greenwich. The practice's main site is located in purpose built premises within the regenerated Kidbrooke village housing development. The practice also has a branch location at 444-446 Rochester Way, Eltham. London. SE9 6LJ.

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures, family planning services, maternity and midwifery services, surgical procedures, treatment of disease, disorder or injury. The practice is able to provide these services to all groups in the population.

The CQC intelligent monitoring placed the practice in band three. 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.

The practice staff team comprised four GPs, a practice nurse, a healthcare assistant, practice nurse, reception supervisor, secretary and a team of 5 reception staff. The practice staff were a long serving team, with the lead GP having been in the practice for 38 years. The healthcare assistant had been in post in the practice for 11 years.

At the time of our inspection the practice had 3860 registered patients. The practice has experienced a reduction in its patient population in recent years whilst the regeneration of the area was taking place, and many people located out of the area. The practice population was growing again, and the management team told us they had noticed a particular increase in the numbers of professional working people registering in the practice.

The practice has a General Medical Services (GMS) contract for the provision of its GP services to the local population.

The practice had opted out of providing out-of-hours services to their patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew.

We carried out an announced visit on 09 December 2014. During our visit we spoke with a range of staff (GPs, nurse, practice manager and administrative staff) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

Staff were encouraged to report significant events by the practice leadership team.

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the healthcare assistant had reported an incident where a patient had experienced breathing difficulties. Records indicated that the practice team had responded and provided them with appropriate care.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the 16 months covering the period June 2013 to October 2014. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the 16 months covering the period June 2013 to October 2014. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts and drug safety alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were disseminated by the practice manager to practice staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that clinical staff had received relevant role specific training on safeguarding children from abuse. We asked members of medical, nursing and administrative staff about the arrangements in place to protect people using the service from abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and properly document safeguarding concerns. They knew how to share this information, and contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. However we saw there were gaps in the training of staff in safeguarding adults from abuse.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The nursing staff, including health care assistants, had been trained to act as chaperone and would do so if requested.

For families, children and young people, there was identification and follow up of children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers).

There was a system in place for identifying patients, including children and young people, with a high number of hospital emergency department attendances. The system also identified vulnerable patients, such as those who were house bound or had complex health needs. Patients with co-morbidities and those prescribed multiple medicines were reviewed at regular intervals.

There was systematic follow up of children who persistently failed to attend appointments, for example for childhood immunisations. The nurse followed up children who did not attend for their childhood immunisations.

Medicines management

Requires improvement

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. However we noted that the fridge temperatures were only monitored and recorded on the days when the practice nurse or healthcare assistant were working. So on a day when these members of staff were not normally working, such as on Thursdays, the fridge temperature was not checked.

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 nurse and health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

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 and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy.

The staff team had undertaken infection prevention and control training; the clinical team had completed their training in May 2014 and the administrative team had completed training in October 2014. All staff in the practice were immunised against Hepatitis B. The clinical staff and some members of the administrative team were also immunised against Meningitis C.

We found that personal protective equipment including disposable gloves, aprons and coverings were available for staff to use whilst treating patients.

Cleaning procedures were in place for key items of equipment such as the handheld spirometer and ear irrigation equipment.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

We saw equipment testing and calibration records indicating these checks had been carried out in August 2014. The equipment tested and calibrated included blood pressure measuring devices, baby weigh scales, ear syringes and thermometers.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However it was unclear from the policy which staff members would be subject to Disclosure and Barring Service (DBS) checks.

We looked at the recruitment records for two members of staff we had been recruited within the last 12 months prior to our inspection. Both were members of the administrative team. We found that certain checks had been completed prior to their employment, such as proof of identification and right to work in the United Kingdom. However, we found that for one member of staff no references had been obtained for them, and that neither staff members had received DBS checks. The practice manager told us that the clinical team were the only staff that had received DBS checks at present, and we were able to verify that the newest recruited GP had been subject to a DBS check. The practice manager told us that they planned to complete the DBS checks for the rest of the staff team.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always

Requires improvement

Are services safe?

enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

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

Arrangements to deal with emergencies and major incidents

The practice must improve their arrangements to manage medical emergencies.

Records showed that some members of clinical and non-clinical staff did not have up to date basic life support training.

Anaphylaxis kits were available in the nurse and healthcare assistant treatment rooms, and in GP consultation rooms. We checked the contents of these kits and saw that the items and medicines were all in date and suitable for use.

Some equipment and medicines recommended for the treating medical emergencies were not available in the practice. There was no oxygen cylinder or automated external defibrillator (used to attempt to restart a person's heart in an emergency) available, and no emergency medicines with the exception of those in the anaphylaxis kits. We found that there had been no risk assessment undertaken as part of the decision process for the medicines and equipment kept in the practice to respond to medical emergencies.

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

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from their local clinical commissioning group (CCG). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse and healthcare assistant supported this work, which allowed the practice to focus on specific conditions.

The practice lead GP attended syndicate meetings in their local CCG area where comparison and benchmarking data was shared.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, monitoring certain aspects of Quality and Outcomes Framework (QOF) performance, and managing child protection alerts and medicines management.

The lead GP told us that the clinical audits the practice carried out were decided by the local clinical commissioning group (CCG) and they also received input from their GP appraiser. We reviewed the summaries of a number of clinical audits that had been carried out in the practice in recent years: an osteoporosis audit in 2012, a chronic obstructive pulmonary disease (COPD) audit in 2013 and an obesity audit in 2014. In each case we found the audits to have been minimal; there were no clear summaries of findings, lessons learnt, actions taken and second cycles of the audits had not been completed.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (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). The latest published QOF data for this practice at the time of our inspection, for the year 2013 / 14, showed that overall it performed below the local area and national averages achieving an overall score of 74.9% which was 14.6 percentage points below CCG average, 18.6 percentage points below England average. For particular conditions including Dementia, Diabetes, Hypertension, and primary prevention of cardiovascular disease, the practice performance in the care of patients in these groups needed to be improved.

However we saw that the practice was performing well against a number of public health indicators within QOF, such as blood pressure measurement in patients over the age of 40, cervical screening and child health surveillance. For the 2013 / 14 year, 94.7% of their patients had a record of their blood pressure check in the preceding five years; this result was 2.9 percentage points above the CCG Average and 6.6 percentage points above the England Average. For women aged between 25 and 64, 77% had notes recording that a cervical screening test has been performed in the preceding 5 years; this result was the same as the CCG average and 0.1% above the England average. The practice offered child development checks at intervals that were consistent with national guidelines and policy.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. During surgery opening hours, there was one GP available for GP appointments at the main site, and a second at the branch location. The practice nurse and the healthcare assistant also worked across both sites. Most of the administrative team worked across the two

Requires improvement

Are services effective?

(for example, treatment is effective)

practice sites, with management continuity achieved by the reception supervisor being based on the main site, and the deputy supervising basing themselves on the branch surgery site.

We noted a good skill mix among the clinical team. There were two doctors with additional diplomas in sexual and reproductive health, and one with a diploma in obstetrics and gynaecology. The practice nurse was a registered mental health nurse as well as a registered general nurse.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We reviewed the staff files of three members of the clinical team, the practice manager and two administrators. Records indicated the staff members had completed relevant training for their roles. The GPs had attended sessions in child protection at levels two and three. The practice nurse had completed training in the management of long term conditions in July 2014. The practice manager had completed training in Notes Summarising and Read Coding (standard clinical terminology system used in General Practice in the United Kingdom) in June 2014.

The administrative staff had completed training on specific topics relevant to their roles such as patient confidentiality, access to medical records, records management and the NHS Code of Practice, and password management.

All staff undertook annual appraisals which included a review of their personal development plans. We looked at the most recent appraisals for four members of staff, all of which had identified learning needs from which action plans were documented.

However from our review of staff records, we found that written job descriptions had not been put in place for the staff team. This had been raised and requested by members of staff during their appraisal meetings.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The duty GP was the allocated person to go through the correspondence and results received on the day. They reviewed these documents and results, and were responsible for the action required.

The practice provided the direct enhanced service (DES) for unplanned admissions. The service was intended to proactively case manage at-risk patients, and required at least 2% of the practice population over 18 years of age to be included in this group. At the time of our inspection, there were 60 patients receiving additional care and support as part of the unplanned admissions DES. The practice had a process in place to follow up these patients if and when they were discharged from hospital.

The practice held quarterly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by the practice clinical team. At times the meeting was also attended by external allied professional such district nurses and palliative care nurses.

The practice was part of a syndicate of 13 local practices in the local CCG area. They held monthly meetings where they discussed and benchmarked their clinical performance. The lead GP at the practice told us the practice performance was in the mid-range when compared with other practices.

The practice maintained links with the local hospital involved the care and treatment of pregnant women. They received information about the antenatal booking of these patients, as well as notes of their delivery. The practice used this information to arrange the six to eight week check on the new mother and baby. The practice also received information on pregnancies that ended in a loss. Patient records were updated, so that wrong information was not sent to the patient causing unnecessary distress.

Information sharing

We spoke with members of the administrative team about the electronic systems in use in the practice. Electronic systems were in place for making referrals, such as through

Requires improvement

Are services effective?

(for example, treatment is effective)

the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use. The staff we spoke with told us they received training on these systems through their clinical commissioning group (CCG).

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

There was a lead member of reception staff for new patient registration. They prepared the new patient file and when the patient's records arrived from their previous practice ensured it was summarised onto the practice electronic system so that their new GP had prompt access to their medical history and any current conditions. All new patients were registered at the main practice site, although they could access appointments at both the practice sites. At the time of our inspection, there were approximately five patients a week registering at the practice.

When patients were removed from the practice list, the administrators followed a process to remove them from the system and send their full patient history on to the health authority.

The practice received information from their out of hours service in the mornings regarding overnight consultations that had taken place with their patients. The details of these consultations were reviewed, and followed up by the GPs if necessary. The GP then carried out any further necessary actions.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. 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. The lead GP also spoke of seeking external expertise from the local mental health Intake and Liaison team.

There was a practice policy for documenting consent for specific interventions. For example, for the implanting of long-acting reversible contraception (LARC). The patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and ill-health prevention

All new patients are offered a consultation following their registration. There was a lead member of reception staff for new patient registration. They took patient details and checked their supporting registration documentation. The reception staff member also booked the patient for their new patient consultation, in agreement with the healthcare assistant or nurse. Following the new patient check consultations, if there were any serious conditions or problems identified, the ne patient was referred for an appointment with the GP to discuss their care and treatment needs in more detail. We spoke with the healthcare assistant about the referrals they might make to the GP from new patients health checks. They told us they would refer any concerning results to the GP for review. However we found that there was no written policy or guidelines indicating what results of blood pressure readings needed to be referred to the GP for review and action.

Patients could be referred for a physical activity scheme in the local borough to help improve their health and wellbeing. The criteria for the scheme referral meant patients with a variety of health conditions could be referred for the scheme including patients with conditions such as depression, hypertension, neurological conditions, pre and post-surgery patients, and those who were overweight or obese. The healthcare assistant told us they had been referring patients to the scheme for 10 years and that they had good results and saw positive health outcomes for their patients.

The practice was also able to refer patients for weight reduction programmes.

Eligible patients, those aged between 40 and 75 years, were referred for NHS health checks. Due to the particular high demand for this service from the practice population, the practice referred patients to other centres and sites that carried out the checks such as pharmacies and larger supermarkets.

The practice offered a number of health screening programmes, including cervical cytology, breast screening and retinal screening.

Requires improvement

Are services effective?

(for example, treatment is effective)

Patients requiring testing for sexually transmitted infections were referred to the local genitourinary medicine (GUM) clinic.

The healthcare assistant carried out an in-house smoking cessation clinic for people who needed that help and support. The healthcare assistant was well supported to deliver this service, attending two to three yearly update seminars and receiving year round support from the local representative in smoking cessation services.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. For the 2012/ 2013 year the practice had provided seasonal flu vaccinations to 76.4% of its patients aged 65 and older; the national average was 73.2%. the practice performance for childhood immunisations was 83.3% for vaccinations offered at 12 months of age. For vaccinations offered at 24 months of age, the practice performance was variable with the lowest levels provided for Meningitis C booster (53.8%) and Measles Mumps Rubella (MMR) combined vaccine (55.8%), and the highest provided for the combined Dtap/IPV/Hib vaccine (82.7%) and infant Meningitis C (80.8%). At the time of writing this report, we did not have comparative data for the overall CCG performance in child immunisation provision.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received six completed comments cards from patients using the practice, all of which were positive and complimentary about the care and treatment provided, and the staff team. Patients complimented the staff team on their friendly manner and their abilities to put them at ease at their appointments.

We spoke with three patients during our inspection. They told us they received good care at the practice, and that they were treated with respect and dignity. One patient with a long term condition told us they had regular checks and monitoring of their condition, and that the outcomes of referral appointments was followed up with them. The patients we spoke with told us the reception staff were helpful and that they found it easy to get appointments when they needed them.

Data from the national GP patient survey showed the practice was similar to national averages for its satisfaction scores on consultations with doctors with 78% of practice respondents saying the GP was good at listening to them and 78% saying the GP gave them enough time.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However, the practice telephone lines were located at the reception desk so telephone conversations could be overheard by people in the waiting area.

Care planning and involvement in decisions about care and treatment

The national GP patient survey information we reviewed showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment with 68% of practice respondents said the GP involved them in care decisions (the national average was 82%).

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.

For older people and people with long-term conditions, there were records that showed care plans were in place for them, and that they were involved in agreeing them.

Patient/carer support to cope emotionally with care and treatment

The nurse was a registered mental health nurse and provided counselling appointments in the practice.

Staff told us a lot of their patients, particularly the older patients, were long term patients registered at the practice for many years, so they knew them well. The practice team received telephone calls from the local hospital bereavement office, notifying them of the death of any of their patients who had died at the hospital. The practice manager or an administrator would email the staff team with the news and the practice team also sent sympathy cards to the bereaved family member. The practice manager also told us they put alerts on the family member's record so that staff were aware and they could be offered additional support such as prioritising them for appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

At the time of our inspection, the practice's patient participation group (PPG) was not active. The practice manager told us this was because some members of the group had moved away during the area regeneration.

We observed positive interactions between the reception staff and patients attending for their appointments, or making enquiries.

The practice was part of a syndicate of 13 local practices in the local CCG area. They held monthly meetings where they discussed and benchmarked their clinical performance. The lead GP at the practice told us the practice performance was in the mid-range when compared with other practices.

Tackling inequity and promoting equality

All the consultation and treatment rooms in the practice were located at ground floor level. There was a disabled parking bay to the front of the premises.

The practice had access to face to face and telephone translation services.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice supported patients who have been on long-term sick leave to return to work. The GP carried out assessments of the patients' capabilities to work and prepared letters detailing the outcomes for the patient and interested parties.

Access to the service

Appointments were available from 08:00 am to 6:30 pm on weekdays. The practice offered booked appointments only. The practice offered an emergency appointment facility, at the end of both the morning and evening sessions. Patients who needed to see the doctor urgently had to telephone at 8am or 3pm to be able to get an emergency appointment, as those were the times additional emergency appointment slots for the day were released.

We spoke with the reception supervisor about the policies and arrangements the practice had in place for providing access to patients. They told us they gave urgent appointments and that two to three such appointments were made available each day. The GP would call the patient back if there were no appointment slots available. The GP then made a decision if there was a need to see the patient after the telephone consultation.

The supervisor explained that due to their patient list size increasing they were finding it more difficult to provide appointments. The next routine appointment was now normally available in three days, when it had previously been available in two days.

Extended hours were offered at the branch surgery between 6.30pm and 7pm on Fridays.

The practice was closed at the weekends and during bank holidays.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

At the time of our inspection the practice did not offer any online services, such as online appointments booking.

We spoke with three patients during our inspection. They all told us they could get appointments in reasonable time, and they had no complaints about the appointments system or the availability of appointments.

The practice reception area was shared with another practice on the same premises. There was signage indicating which staff to approach about each practice.

The reception area was located immediately adjacent to the front door to the premises. Staff in the reception area answered queries people were making in person, and signed in patients for their appointments. They also answered phone calls made to the practice. Although we didn't observe confidential or personal information being disclosed, the front desk arrangements did not allow for confidential conversations to be held.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

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

We looked at the summary of the complaints received in the 12 months prior to our inspection. Most of the complaints received were verbal, with very few written complaints made to the practice. We saw that the complaints were responded to in a timely manner, and that actions were taken in response to complaints, such as additional staff training and the details of complaints were discussed at clinical meetings.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

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 senior practice GP articulated the practice vision as being to improve the public's health and to enable them to lead normal lives. Staff were clear about the vision and their responsibilities in relation to the practice values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures and saw they had been periodically reviewed and were up to date. Although policies and procedures were in place, we found instances where they were not properly followed such as with the recruitment procedures and staff appraisals.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. Staff we spoke with all told us they felt valued, well supported and knew who to go to in the practice with any concerns. However records showed that staff did not have up to date job descriptions in place, despite some of them raising this during their appraisal meetings.

The clinical team and the practice manager took lead roles in monitoring different aspects of Quality and Outcomes Framework (QOF) performance such as clinical, public health and enhanced services. The lead roles were allocated according to particular staff members' strengths, interests and clinical expertise. For example, the lead GP for contraception services also carried out long-acting reversible contraception (LARC) procedures in the practice.

The latest published QOF data for this practice at the time of our inspection, for the year 2013 / 14, showed that overall it performed below the local area and national averages achieving an overall score of 74.9% which was 14.6 percentage points below CCG average, 18.6 percentage points below England average.

We found that audits were not properly completed in the practice. . We reviewed the summaries of a number of clinical audits that had been carried out in the practice in recent years: an osteoporosis audit in 2012, a chronic obstructive pulmonary disease (COPD) audit in 2013 and an obesity audit in 2014. In each case we found the audits to have been minimal; there were no clear summaries of findings, lessons learnt, actions taken and second cycles of the audits had not been completed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least 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. Staff also told us that team events were held regularly to celebrate and foster good working relationships.

The practice manager was responsible for human resource policies and procedures. We reviewed the recruitment policy which was in place in the practice, but found that there was not a clear policy regarding which staff members would be subject to Disclosure and Barring Service (DBS) checks, and that the recruitment policy had not been properly followed in the recruitment of the most recent administrative staff to join the practice.

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

Patients were able to provide feedback through the friends and family test. The system had been introduced on a pilot basis since October 2014, but was going live formally in December 2014.

Administrative team meetings were held monthly. These were attended by the practice manager, secretary, and other administrative staff. Staff we spoke to described it as a meeting where they could discuss and raise concerns, and request for any additional help they required for their work and the operation of the practice. An example of a matter that had been raised at the reception meeting was lone working. Following the discussion, the practice management team changed the policy on lone working in the reception area, and it was now the standard to have two receptionists on duty at all times.

Practice team meetings were held monthly, and attended by all staff.

Clinical meetings were held monthly, and attended by the GPs, nurse, healthcare assistant and practice manager.

Are services well-led?

Requires improvement

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

Staff we spoke with told us the management team and their colleagues were supportive, and that they had had long working relationships with most of them. The practice staff arranged team and social events to celebrate and foster their strong working relationships.

All staff undertook annual appraisals which included a review of their personal development plans. We looked at the most recent appraisals for four members of staff, all of which had identified learning needs from which action plans were documented. However from our review of staff records, we found that written job descriptions had not been put in place for the staff team. This had been raised and requested by members of staff during their appraisal meetings.

The patient participation group (PPG) was not active at the time of our inspection due to a reduction in PPG members as patients had moved away from the area.

Management lead through learning and improvement

The clinical staff received protected learning time for their professional training and development. For example, the practice nurse had completed training in the management of long term conditions during their protected learning time.

The practice was an approved provider of work experience in Health Service Administration. They offered placements to school leavers interested in working in this field for a number of weeks at a time.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character. Regulation 21 (a) (i), which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have a clear policy regarding which staff members would be subject to Disclosure and Barring Service (DBS) checks, and their recruitment policy was not followed in the recruitment of new staff.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. This was because the planning and delivery of treatment was not always in such a way as to ensure the welfare and safety of the service user. Regulation 9 (1)(b)(ii), which corresponds to regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider needs to improve their arrangements for managing medical emergencies.