

Jacksdale Medical Centre

Quality Report

Main Street
Jacksdale
Nottingham
NG16 5JW

Tel: 01773 608760

Website: www.jacksdalemedicalcentre.co.uk

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Jacksdale Medical Centre on 6 March 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe and well led services. It was rated good for providing effective, caring and responsive services. The concerns we identified in the safe and well-led domains relate to everyone who uses the practice including the population groups. Therefore all the population groups we inspected were rated as requires improvement.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, information about safety was not always recorded, monitored, appropriately reviewed and addressed.

- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments.
- The practice had a number of policies and procedures to govern activity. The practice did not hold regular governance meetings.

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

Importantly, the provider must:

Summary of findings

- Ensure the methods used for recording, reporting, investigating, review and dissemination of learning from significant events, near misses and complaints are robust.
- Ensure that all necessary employment checks are obtained and kept of file.

In addition the provider should:

- Strengthen infection prevention and control processes.

- Ensure audits complete their full cycle in order to demonstrate improvements made to practice.
- Introduce a system for checking that equipment is in date.
- Record all complaints and introduce a system to review complaints for trends or themes.

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 as there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, records did not demonstrate that reviews and investigations were thorough enough and lessons learned were not communicated widely enough to support improvement. 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. For example, immunisation status of staff and a legionella risk assessment. The practice had a policy in place for repeat prescribing but not all of the signed Patient Group Directions were available. There was no evidence to support that the necessary employment checks had been obtained before staff started their employment.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Health promotion and prevention was routinely and opportunistically offered to reduce risks to patients' health. Staff had received training appropriate to their roles, although records were not in place to support this. 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 some but not all staff. Staff worked with multidisciplinary teams. We saw limited evidence to demonstrate that clinical audit was driving improvement in performance to improve patient outcomes.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said 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 also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to

Good



Summary of findings

secure improvements to services where these were identified. Feedback from patients reported that access to a GP and continuity of care was not always available quickly, although urgent appointments were usually 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. However, informal complaints were not recorded, so the practice was not able to review complaints to detect themes or trends.

Are services well-led?

The practice is rated as requires improvement for being well-led.

There was a leadership structure in place and most staff felt supported by their line manager. Staff felt able raise issues with the practice manager, but not within practice meetings. They were aware of their roles and responsibilities. There was a limited approach to obtaining staff feedback. The practice had a number of policies and procedures to govern activity, although these were not always followed, for example the recruitment policy.

The systems in place for assessing and monitoring service provision were not always robust to ensure all risks were appropriately managed. Whilst clinical audits had been completed, none of these were a completed audit cycle where the practice was able to demonstrate the changes resulting since the initial audit. There was no evidence to support that governance meetings were held.

The practice engaged with the patient participation group (PPG) to seek patient feedback and improve the service. The PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Requires improvement



Summary of findings

The six population groups and what we found

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

Older people

The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Every patient over the age of 75 years had a named GP. Influenza and shingles vaccinations were offered to older patients in accordance with national guidance. Home visits to patients in their own homes or care homes were carried out when requested. Monthly multi-disciplinary care meetings were held to ensure integrated care for older people with complex health care needs.

Requires improvement



People with long term conditions

The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

We found that the nursing staff had the knowledge, skills and competencies to respond to the needs of patients with a long term condition such as heart disease and asthma. Longer appointments and home visits were available when needed. The practice maintained registers of patients with long term conditions. All these patients were offered structured annual review to check that their health and medication needs were being met. Recall systems were in place to ensure patients attended.

Requires improvement



Families, children and young people

The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

We saw that the practice provided services to meet the needs of this population group. Urgent appointments were available for children who were unwell. Staff were generally knowledgeable about how to safeguard children from the risk of abuse. Systems were in place for identifying children who were at risk, and there was a good working relationship with the health visitor attached to the practice.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was pro-active in offering on line services as well as a full range of health promotion and screening services which reflected the needs of this age group. The practice offered all patients aged 40 to 74 years old a health check. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice.

Requires improvement



People whose circumstances may make them vulnerable

The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients with a learning disability. It had carried out annual health checks for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. Most 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.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice was proactively assessing patients with risk factors associated with dementia. The practice regularly worked with

Requires improvement



Summary of findings

multi-disciplinary teams in the case management of patients experiencing poor mental health. The practice had direct links to the mental health crisis team, and ensured that patients and families had contact details for access when the practice was closed.

Summary of findings

What people who use the service say

We spoke with five patients on the day of the inspection. Patients were mostly satisfied with the service they received at the practice. They told us that clinical staff treated them with care and concern. Four of the five patients told us that it was difficult to access GP appointments and they had to ring at 8am, and even then didn't always get an appointment and had to phone back the following morning. However, one of these patients told us that when they rang for an urgent appointment for their child, they were seen the same day.

We reviewed the 26 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments were positive. Patients said they felt the practice offered a good service and staff were helpful, caring and

professional. They said staff generally treated them with dignity and respect. Eight patients made comments that were less positive but these were all about the waiting time to get an appointment with the GP.

We looked at the practice's own patient survey which showed that 73% of patients said there were no appointments available on the day requested, and only 18% thought the appointment system was very good. The practice's action plan dated July 2014 stated that the practice was looking at introducing the on line booking facility for appointments. This was operational at the time of this inspection.

We looked at the national patient survey published in January 2015. The survey found that 69% of patients rated Jacksdale as good or very good. The results showed that 50% of patients would recommend the practice to someone new to the area, which placed them in the worst 25% of scores nationally.

Areas for improvement

Action the service **MUST** take to improve

- Ensure the methods used for recording, reporting, investigating, review and dissemination of learning from significant events, near misses and complaints are robust.
- Ensure that all necessary employment checks are obtained and kept of file.

Action the service **SHOULD** take to improve

- Strengthen the infection prevention and control processes.
- Ensure audits complete their full audit cycle in order to demonstrate improvements made to practice.
- Introduce a system for checking that equipment is in date.
- Record all complaints and introduce a system to review complaints for trends or themes.

Jacksdale Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission lead inspector. The lead inspector was accompanied by a GP specialist advisor, a Practice Manager specialist advisor and an expert by experience who had personal experience of using primary medical services.

Background to Jacksdale Medical Centre

Jacksdale Medical Centre is located in the village of Jacksdale, close to the Nottinghamshire / Derbyshire border. The practice provides services to people who live in Jacksdale and the surrounding villages.

The practice is a single handed GP practice, with support from two regular locum GPs. There is also a locum practice nurse, three health care assistant, practice manager and reception / administration staff. There are 3972 patients registered with the practice. The practice is open from 8am until 6pm Monday to Friday. The practice offers extended hours with the practice nurses on Mondays and Wednesdays. Additional appointments are available on these days for 7am until 8am. The practice treats patients of all ages and provides a range of medical services.

The practice holds a Personal Medical Services (PMS) contract with NHS England. This is a contract for the practice to deliver enhanced primary care services to the local community over and above the General Medical Services (GMS) contract.

Jacksdale Medical Centre has opted out of providing an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. The out of hours service is provided by PC24 via NHS 111.

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 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.

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

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Area Team.

We carried out an announced visit on 6 March 2015. During our inspection we spoke with the GP, a locum GP, two

Detailed findings

practice nurses, a health care assistant, the practice nurse manager and two members of reception/administration staff. We spoke with five patients who used the service about their experiences of the care they received. We reviewed 26 patient comment cards sharing their views and experiences of the practice. We also spoke with staff from two local care homes.

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)

Are services safe?

Our findings

Safe track record

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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the 12 months. This showed the practice had not managed these consistently over time and so could not 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 previous year and we were able to review these.

Significant events were raised by completion of a standard form which was submitted to the practice manager. Two significant events had been recorded during 2014. We tracked both incidents and saw that although discussion and action had taken place, there was no evidence of investigation. We also saw that significant events were not always reviewed to minimise the risk of reoccurrence. One incident recorded a review date of July 2014, this date had passed with no review of the incident. There was no evidence to support that significant events were reviewed annually. The practice was not able to evidence that issues had been discussed and followed up. Although staff told us significant events were discussed at practice meetings, we did not see any minutes that covered any discussions around significant events.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were not able to give examples of recent alerts that were relevant to the care they were responsible for. One practice nurse told us they were responsible for checking the information in the alert and taking any appropriate action on behalf of the nursing team.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff spoken with told us they had received training on safeguarding vulnerable adults and children. However, the training records did not support that all staff had received training. We asked members of the nursing staff about their knowledge and understanding about safeguarding or how to recognise signs of abuse in older people, vulnerable adults and children. A practice nurse was able to describe circumstances when they had made a referral to the safeguarding team. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that the contact details for safeguarding teams were easily accessible.

Staff told us they had links with the health visitor, although they did not have regular formal meetings. The practice nurses described circumstances where they had discussed their concerns about a family with the health visitor. They told us these concerns were recorded on the electronic notes. Children who did not attend for immunisations were also followed up by a health visitor when this was required.

The GP acted as the lead for safeguarding vulnerable adults and children. They had been trained to an appropriate level and could demonstrate they had the necessary knowledge to enable them to fulfil this role. Staff we spoke with told us they would speak with either of the GPs if they had a safeguarding concern.

There was a system to highlight vulnerable adults and children on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or patients with learning disabilities, or on the admission avoidance register.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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). Records demonstrated that some but not all staff who acted as chaperones had received training. In addition, these staff did not have the Disclosure and Barring Service (DBS) checks or risk assessments in place.

Are services safe?

Medicines management

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.

Processes were in place to check medicines were within their expiry date and suitable for use. We were told that there was a designated member of staff responsible for managing the medicines held in the practice. We checked the storage and stock control of the medicines held in the practice. We found that medicines were well organised and kept in locked cupboards or refrigerators. The practice nurse told us that they did not have a system to monitor stock levels of all medicines in the practice, only the emergency medicines. All the medicines we checked were within their expiry dates. The practice told us that expired and unwanted medicines were taken to the community pharmacy next to the practice for disposal.

We spoke with the Clinical Commissioning Group (CCG) prescribing advisor. They told us they had a good working relationship with the practice, and worked together to ensure the practice remained within budget for prescribing. The CCG benchmarked the practice against other practices in the locality and this practice was under budget for prescribing. The prescribing advisor told us they had agreement from the GP to initiate changes to patient medicines in response to updates to the preferred prescribing list. We saw from the data we reviewed that the pattern of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were similar to national prescribing levels.

Staff told us there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. However, the PGDs seen had not all been signed by the GP as well as the nurse. We saw evidence that nurses had received appropriate training to administer vaccines.

The practice had a policy in place for repeat prescribing. All prescriptions were reviewed and signed by a GP before

they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

All of the patients we spoke with during the inspection told us that the practice was always clean and tidy, and we observed this to be the case. The practice employed cleaning staff twice a week and we saw that cleaning schedules were in place. The practice manager told us that audits of the cleanliness were carried out. These were not seen at the time of this inspection.

The practice did not have a lead for infection control. We saw that some but not all staff had received infection control training specific to their role. It was not clear from the records how frequently this training was updated. An infection control audit had been carried out by the county council in March 2014, and a number of recommendations were made. The practice had developed an action plan following the audit, and told us that the actions had been completed. The practice manager told us re-audits were carried out at the discretion of the county council.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. However, bodily fluid spillage kits were not available in the practice.

The practice had not taken reasonable steps to protect staff and patients from the risks of health care associated infections. The practice could not demonstrate that relevant staff had received appropriate immunisations and support to manage the risks of health care associated infections. There was a policy for needle stick injuries. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients did not have access to antibacterial hand rub in the waiting room.

Are services safe?

The practice had limited information in place for the management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal) although a written risk assessment was not in place. Records available recorded what action had been taken but was not signed. The practice manager told us the water temperatures were checked about every five weeks, but the water was not tested for legionella. They told us that taps were run daily although there were no records to support this.

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. The practice had an asset register / inventory of all equipment available. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of the contract in place for the calibration of relevant equipment; for example blood pressure monitoring equipment.

However, we found that the practice did not have a system in place to check the expiry dates of equipment such as sterilised surgical instruments, scalpels and sutures. We found equipment where the expiry date had passed in the treatment room. The practice nurse disposed of this equipment during the inspection.

Staffing and recruitment

The practice was unable to demonstrate that effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. Although a recruitment policy was in place, there was no evidence to support it was being followed. There were no staff recruitment files in place. We looked at the records of the recently appointed practice nurse, and the only check on file was confirmation they were registered with their professional body. There was no evidence of the criminal records checks through the Disclosure and Barring Service (DBS), satisfactory evidence of conduct in previous employment, a full employment history or satisfactory evidence about any health related conditions.

DBS checks had not been requested for any other staff who worked at the practice, and risk assessments had not been carried out on the different staff groups to assess which staff needed to have a DBS check in place.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Reception staff were flexible and would do extra hours to cover holidays and sickness. There were two practice nurses although one was due to retire in the near future.

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. The practice also had a health and safety policy.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. All risk assessments were updated on an annual basis. The practice manager told us that risk assessments were discussed with the practice team prior to updating.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. The practice used 'E-Healthscope' which was an information tool supported by the Clinical Commissioning Group (CCG). This enabled the practice to identify patients who had attended accident and emergency or been admitted to hospital. The needs of these patients were discussed at the integrated care team, a team that included health and social care staff such as community matrons, specialist nurses and social workers. One patient commented that the reception staff had recognised they were unwell when they had visited to make an appointment and made a same day appointment for them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Nursing staff also received training on anaphylaxis (severe allergic reaction). Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When

Are services safe?

we asked members of staff, they all knew the location of this equipment. Staff told us that the equipment was checked monthly although they did not record this information.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylactic shock. The practice did not have medicines to treat low blood sugar. Staff told us they would dial 999 and call an ambulance in the event of an emergency if a clinician was not in the building. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of the medicines we checked were in date and fit for use.

A basic business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The practice had an agreement with the local practice to use their premises in the case of an emergency, and a copy of the business continuity plan was kept at that site. However, there were no details of emergency contacts, essential services or risk assessments included in the business continuity plan.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that some staff but not all had attended fire training. It was not clear from the records how frequently this training was updated. Staff had attended a fire drill in February 2014.

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. The practice did not have a system in place for the dissemination of any new guidance. One practice nurse told us it was their responsibility to keep up to date with changes to NICE guidance, although occasionally any changes were discussed in meetings. We found from our discussions with the nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice nurses led in specialist clinical areas such as diabetes, heart disease and asthma and were supported by the GPs where required. This allowed the practice to focus on specific conditions. One of the practice nurses told us they were behind with the reviews of patients with asthma and chronic obstructive pulmonary disease (chronic lung disease) due to a period of maternity leave. The practice was identifying patients who needed to be reviewed, so they could be invited to make an appointment.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audits. The practice showed us three clinical audits that had been completed in the last year, for example attendance at accident and emergency. None of these were a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. The practice did not undertake audits in the effectiveness of the minor surgical procedures provided, for example, infection or complication rates.

We reviewed the most recent data available from the previous year 2013/2014 in the Quality and Outcomes Framework (QOF). 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 practice had results below or significantly below the national average in four of the clinical outcomes we looked at. All four of the outlying outcomes related to the care of patients with diabetes. At

the time of the inspection one of the practice nurses was identifying diabetic patients that needed to attend for their annual review. The practice achieved 84.2% QOF points out of a possible 100%, which was above the national average. The practice manager told us that informal meetings were held to discuss the QOF data every month.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The practice was supported by the prescribing advisor from the local Clinical Commissioning Group, who flagged up relevant medicine alerts and identified patients on this particular medicine. There was an agreement in place for the prescribing advisor to amend patients' medicines as required.

The practice had implemented principles of delivering appropriate individual care to patients who were approaching the end of their life. It had a palliative care register and held monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff told us they received training appropriate to their role. However, there were no training records available for one of the practice nurses or the locum GP. The main GP was up to date with their yearly continuing professional development requirements and all either have 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).

Not all staff had received an annual appraisal that identified learning needs from which action plans were documented. Our interviews with nursing staff confirmed that the practice was proactive in providing training and funding for relevant courses. The local Clinical Commissioning Group (CCG) supported ten protected learning sessions each year for GP and nursing staff. The nursing staff told us they attended these. Administrative staff often completed in house training during these sessions.

Are services effective?

(for example, treatment is effective)

The nursing team were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, sexual health and family planning. Those with the extended roles of providing annual health reviews for patients with long term conditions such as asthma, diabetes and heart disease were able to demonstrate that they had appropriate training to fulfil these roles.

We checked the professional registrations of the GPs and practice nurses with the relevant professional regulatory body. These were all current and valid.

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. Administrative staff were able to describe the process and responsibilities for passing on, reading and acting on any issues arising from communications with other care providers. The GP who saw these documents and results was responsible for recording the action required. Staff told us that this tended to be a paper based process rather than electronic. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs or who required additional support. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

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

this system was easy to use. The practice manager told us that the local Clinical Commissioning Group monitored all referrals and the data for each practice was discussed at the locality meetings.

The practice had signed up to the electronic Summary Care Record and this was fully operational. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. The practice had also just started to use the GP2GP electronic system. This system enabled patients' Electronic Health Record (EHR) to be transferred electronically from their previous GP practice.

The practice used an electronic system between the practice and the local hospital for blood tests, x-rays requests and results. Staff told us that the system helped to reduce errors, for example from hand written forms as the information was printed directly from the system. The system also flagged if the same test had recently been requested and alerted the hospital that the bloods or requests were on their way.

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

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act 2005, and the assessment of Gillick competency of children and young adults. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

We saw that the GP and one of the practice nurses had received training on the Mental Capacity Act 2005. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. The other practice nurse told us that they not received any training at the practice, although the subject

Are services effective?

(for example, treatment is effective)

had been discussed briefly during a protected learning session. Nursing staff told us if they had any concerns about a person's capacity to make decisions, they would advise the GP.

Staff told us that GPs had sought the patient's consent to certain decisions, for example, 'do not attempt resuscitation' care plans. They told us the appropriate paperwork was completed and scanned on to the electronic system. The staff representative from one of the care homes told us that GPs reviewed the 'do not attempt resuscitation' care plans when they visited to home to see the patient.

There was a practice policy for documenting consent for specific interventions. For example, for all invasive procedures written consent from the patient was obtained. Nursing staff told us that consent for childhood immunisations was recorded in the personal child health record.

Health promotion and prevention

When registered at the practice new patients were required to complete a questionnaire providing details of their medical history. It was practice policy to offer all new patients a consultation with the GP.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations and referral to smoking cessation

programmes. We were also told that the practice carried out child immunisations and offered sexual health and family planning advice and support. The nursing staff told us they use their contact with patients to help maintain or improve mental, physical health and wellbeing, for example advice on healthy eating.

The practice nurse told us they encouraged newly diabetics to attend the 'TIIDe' course at the local hospital. This was a six week educational course on diet and nutrition, and included practical advice around cooking and food awareness. Diabetic patients were also given a folder containing written information and guidance on how to manage their diabetes.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were invited by letter or telephone to attend for a health check.

Flu vaccination was offered to all over the age of 65, and those between 6 months and 65 years in the at risk groups. The percentage of eligible patients receiving the flu vaccination was within the national average for both groups.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was generally in line with the average for the local Clinical Commissioning Group.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 101 replies to the national patient survey carried out during January-March 2014 and July-September 2014 and a survey of 132 patients undertaken by the practice's patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The evidence from these sources showed patients were satisfied with how they were treated and that this was with care and concern. For example, data from the national patient survey showed that 69% of patients rated their overall experience of the practice as good or very good. The survey showed that 76% of patients felt that the doctor was good at listening to them, with a score of 89% for the nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and professional. They said staff generally treated them with dignity and respect. Eight patients made comments that were less positive but these were all about the waiting time to get an appointment with the GP. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 / 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. We saw that due to the layout of the building, confidentiality was difficult to maintain. However, we saw that staff made efforts to minimise any risk. When there were no patients in the waiting room, the glass doors on the reception desk

were closed to prevent conversations being overheard. The waiting room was small so conversations between patients and staff could easily be overheard. Reception staff told us that if a patient wished to speak with them confidentially, they would take them into a separate room. There was no information in the waiting room to inform patients about this. However, none of the patients spoken with during our inspection expressed any concerns about their privacy or confidentiality.

Staff told us that the practice cared for patients whose circumstances may make them vulnerable. This included people living in care homes and people with a learning disability or mental health need. Staff told us that these patients were supported to register as either permanent or temporary patients as the practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

There was information on the practice's website stating the practice's zero tolerance for abusive behaviour. This information was also on display in the reception area.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff. One patient commented that the GP had listened to their concerns about their condition and supported them, as well as offering options to try and resolve the issues. Patients' comments on the comment cards we received were also positive and supported these views. A patient commented that they felt happy to ask the GP or nurses any questions about their care or treatment; another commented that they never felt rushed.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice reasonable in these areas. For example, data from the national patient survey showed 71% of practice respondents said the GP involved them in care decisions

Are services caring?

and 65% felt the GP was good at explaining treatment and results, which was below the local Clinical Commissioning Group (CCG) average. The results were higher for the nurses, with 79% of practice respondents said the nurse involved them in care decisions and 90% felt the nurse was good at explaining treatment and results.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or who had additional needs due to their medical condition. For example, long term conditions, those with a learning disability or mental health difficulties, and those requiring end of life care. Individual care plans had been developed for these patients. Integrated care multi-disciplinary meetings between GPs, community based nurses, social workers, and specialist nurses were held monthly to review the care of the most vulnerable patients. We saw systems were in place to ensure patients with a long term condition received a health review at least annually. This included patients for example with coronary heart disease, diabetes, chronic obstructive pulmonary disease (chronic lung disease) and asthma.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 74% of patients surveyed said that the last GP they saw or spoke with was good at treating them with care and concern with a score of 90% for nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The lead GP told us if families had suffered bereavement, an active management plan was put in place. There were pathways in place to refer patients to bereavement counselling if required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was generally responsive to patients' needs and had systems in place to maintain the level of service provided. For example, the practice offered early morning appointments twice a week with the practice nurses for patients with work commitments. The practice provided a range of services in house, for example, phlebotomy (taking blood), cervical smears, management of long term conditions, child immunisation and travel vaccinations.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice did engage regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The CCG told us that patients from the practice had been identified as high users of services such as accident and emergency and walk in centres. They had also identified that there were a high number of outpatient referrals where patients were discharged without any treatment. We saw that although the GP attended the protected learning days, the locum GPs employed at the practice did not. The CCG primary prescribing pharmacist told us that it would be beneficial if the main locum GP attended the meetings between the practice and themselves.

The practice had an active Patient Participation Group (PPG) to help it to engage with a cross section of the practice population and obtain patient views. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The PPG had eight members, who met with the practice manager every three months. The PPG assisted the practice to carry out a patient satisfaction survey and develop the action plan in 2014. The PPG also support the practice with 'meet and greet' sessions, where representatives sit in reception and speak with patients about their experiences at the practice. These sessions occurred more frequently at Dr Rajah's other practice than at Jacksdale. Issues raised with the PPG regarding Jacksdale were around the lack of available appointments. Information about the PPG and the patient survey was on the practice website. Minutes of previous meetings were also available on the website.

We spoke with representatives from three local care homes. They told us they were satisfied with the service provided

by the practice. They said the locum GP visited on request to review patients who required a GP visit. They told us the practice was responsive to any requests for changes to medicines.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning for all staff and we saw evidence of this. Staff we spoke with confirmed that they had completed the equality and diversity training. We looked at the training matrix in place at the practice and saw that it identified what training had been completed.

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, people who were homeless. Staff told us that these patients were supported to register as either permanent or temporary patients. The practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us they did not have access to a translation service, although the midwife can access this service. They told us the largest minority group registered at the practice were of east European origin, and a member of their community supported patients during their consultations. We saw that the website also had the facility to translate information into different languages.

The practice was located in a single storey building. We saw that although the waiting area was small, the chairs were arranged to accommodate patients with wheelchairs and pushchairs. There was a notice in place that informed patients that pushchairs were not allowed to be taken to the consulting rooms. The practice manager told us that this was due to fire regulations. Facilities for patients with mobility difficulties included a step free access to the front door of the practice and disabled toilets.

Access to the service

The practice website outlined how patients could book appointments and organise repeat prescriptions online. This included how to arrange urgent appointments and home visits. Patients could also make appointments on line, via the telephone or in person to ensure they were

Are services responsive to people's needs?

(for example, to feedback?)

able to access the practice at times and in ways that were convenient to them. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. The contact telephone number for the out of hours service was published on the practice website and also included in the answerphone message when the practice was closed.

The practice opened from 8am until 6pm on Tuesdays, Thursdays and Fridays, 7am until 6pm on Mondays and 7am until 1pm on Wednesdays. GP appointments were available from 9.30am until 12 noon, and 3.30pm until 6pm (except Wednesday). Nurse appointments were available from 7am until 12.30pm on Mondays and Wednesdays, and 8.30am until 12.3pm on Tuesdays, Thursdays and Fridays. Afternoon appointments from 4pm until 6pm were available every day except Wednesday. The practice also offered a phlebotomy (blood sample taking) service.

Staff told us that the early morning appointments with the practice nurses were well attended. These appointments were particularly useful to patients with work commitments. The practice manager told us that the availability of GP appointments on a daily basis was half pre-bookable and half bookable on the day, with two appointments available for emergencies. They told us that follow up appointments often took up the majority of the pre-bookable appointments.

Not all patients were satisfied with access to the service. Data from national patient survey published in January 2015 showed that 47% of patients were satisfied with the practice's opening hours. This was below the local Clinical Commissioning Group (CCG) average of 76%. Comments on the CQC comment cards (eight out of 26) indicated that patients had to wait two to three weeks to get an appointment with a GP. Four of the five patients spoken with during the inspection told us they could not always get an appointment, and they had to ring at 8am, and even then didn't always get an appointment and had to phone back the following morning. In the practice's own patient survey 73% of patients said there were no appointments available on the day requested, and only 18% thought the appointment system was very good. The practice's action plan dated July 2014 stated that the practice was looking at

introducing the on line booking facility for appointments. This was operational at the time of this inspection. We looked at the national patient survey results and saw that 53% of respondents described their overall experience of making an appointment as good compared with the regional CCG average of 75%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were not 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 a poster was on display in the waiting room and the complaints procedure included on the website. However the complaints policy on the website made reference to the Primary Care Trust, which was replaced by the Clinical Commissioning Group in April 2013. None of the patients we spoke with had ever needed to make a complaint about the practice, although one patient commented that they wouldn't know how to. Staff spoken with told us they would try to resolve any issues themselves but would refer complaints to the practice manager if required.

The practice manager told us they had received two complaints during the previous 12 months. The practice had invited the Medical Protection Society (MPS) to investigate one of these complaints and the investigation was ongoing. The MPS is a protection organisation for medical, dental and healthcare professionals. We saw that the other complaint had been fully investigated and the patient informed of the outcome of the investigation in writing. Due to the nature of the complaint, the practice had also recorded it as a significant event.

The practice manager told us they would speak with any patient who wished to verbally complain about the service. However, these informal complaints were not recorded. As all complaints were not recorded, the practice was not able to review complaints to detect themes or trends.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice's mission statement was included on the practice website. It was to treat all patients equally and to give a high standard of service that is sensitive to their needs. The purpose of the practice was to provide patients with personal health care of high quality and to seek continuous improvement of the health of the practice population. This and the aims and objectives were included in the statement of purpose. This information was not displayed in the waiting areas or around the practice, to inform patients and staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff as paper copies. Staff spoken with told us that the policies and procedures were kept in the practice manager's office. The policies and procedures seen had been reviewed and were up to date.

The practice had some systems in place to assess and monitor the quality of services. However, we found areas where systems to promote robust governance were not always in place or were inconsistently followed. For example the practice had not followed their recruitment policy when recruiting a member of clinical staff. This included ensuring good conduct in previous employment, criminal records checks through the Disclosure and Barring Service (DBS) and establishing the status of a health care worker's immunity to vaccine-preventable illness or disease. The result of not following governance in a robust way could put a patient at increased risk of harm from improper treatment or avoidable illness.

The GP carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. None of these were a completed audit cycle where the practice was able to demonstrate the changes resulting since the initial audit.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF is an incentive scheme rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The QOF data for this practice showed it was

performing below the national average. The practice manager told us that QOF data was discussed at monthly meetings, and action plans developed to maintain or improve outcomes.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log. All risk assessments were updated on an annual basis. The practice manager told us that risk assessments were discussed with the practice team prior to updating.

Leadership, openness and transparency

We saw from minutes that practice meetings were held every two weeks, and clinical meetings were held monthly. We saw minutes from these meetings. Staff told us they were happy to raise any issues with the practice manager, but more reserved about raising issues at team meetings.

The practice manager was responsible for human resource policies and procedures. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and comment cards and complaints. The practice had a virtual Patient Participation Group (PPG) to help it to engage with a cross section of the practice population and obtain patient views. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. Following the 2013/2014 patient survey, the practice implemented a number of changes. These included the introduction of on line booking for appointments and changes to the extended hours.

The practice had gathered feedback from staff through staff meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns with the practice manager, although some were reluctant to raise issues during practice meetings.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. One of the practice nurses told us they were being supported by the practice to undertake the practice nurse training. One member of staff spoken with told us they had received an annual appraisal although there was evidence to support that other staff had.

Are services well-led?

Requires improvement



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

We did not see any evidence to support that the outcome of clinical audits and reviews of significant events were shared with staff to ensure the practice improved outcomes for patients. The records available did not demonstrate that concerns, near misses, significant events (SE's) and all

complaints were appropriately logged, investigated and actioned. There were no minutes to demonstrate the sharing of information the nursing team or non-clinical staff.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision</p> <p>People using the service were not protected against the risks of inappropriate or unsafe care and treatment because of the lack of robust methods for recording, reporting, investigating, review and dissemination of learning from significant events, near misses and complaints.</p> <p>Regulation 10 (a)(b) & 2(c)(i)</p> <p>This corresponds to Regulation 17(1) (2)(a)(b) of the (Regulated Activities) Regulations 2014</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers</p> <p>People using the service were not protected against the risks of inappropriate or unsafe care and treatment because the required information as outlined Regulation 21 and Schedule 3 (Information Required in Respect of Persons Seeking to Carry On, Manage Or Work For The Purposes of Carrying On, A Regulated Activity) was not recorded.</p> <p>Regulation 21 & Schedule 3</p> <p>This corresponds to Regulation 19 and Schedule 3 of the (Regulated Activities) Regulations 2014</p>