# Dr Veena Sharma

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

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

We carried out an announced comprehensive inspection at Dr Veena Sharma on 30 August 2016. This comprehensive inspection was carried out to check that the practice was meeting the regulations and to consider whether sufficient improvements had been made since the previous inspection in November 2015.

Our previous inspection in November 2015 found breaches of regulations relating to the safe, effective, caring and responsive delivery of services. There were also concerns and regulatory breaches relating to the management and leadership of the practice, specifically in the well led domain. The overall rating of the practice in November 2015 was inadequate and the practice was placed into special measures for six months.

During the inspection in August 2016, we found evidence that improvements had been made. However, the practice is rated as requires improvement overall as there had been insufficient time since new systems and processes were implemented to evidence that improvements have been embedded and can be maintained. Specifically it is rated requires improvement for the provision of safe, caring and well led services and good for provision of effective and responsive services. Our improved rating of requires improvement for the provision of well led services reflects the positive development of leadership and management systems to deliver significant progress in improving services across the board for all patient groups. However, improvements are still required.

Overall the practice is rated as requires improvement.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were not fully assessed and well managed. For example, emergency medicines could be inaccessible if needed in an emergency.
- The business continuity plan and other policies were not comprehensive or reflected current guidelines.

# Summary of findings

- The practice had not ensured that all recruitment checks had been completed.
- The policy for tracking blank prescription stationery was not being followed
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment by GPs but satisfaction for the nursing team was lower.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a newly established leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- Urgent appointments were available on the day if they were requested.
- The practice evidenced that they had made positive changes to the governance arrangements, however, as systems were newly implemented there was limited to evidence to show that they were fully embedded and effective.
- Data showed patient outcomes were high for the locality.

The areas where the provider must make improvements are:

- Ensure governance systems are fully embedded and maintained within the practice.
- Ensure policies are reviewed to reflect up to date information; risks in relation to the safety of patients are fully assessed and managed; implementing and improving the business continuity plan to ensure the practice is able to maintain services in an emergency or during an event which impacts on the level of service.
- Ensure emergency equipment is regularly checked and emergency medicines are accessible in the event of an emergency.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all nursing staff receive level 2 safeguarding training.

The areas where the provider should make improvement are:

- Ensure prescription stationery is tracked to individual practitioners in line with current guidance and the practice policy.
- Review and improve the identification of carers in order to provide the required support to these patients.
- Continue to monitor and make improvements to address identified concerns with patient feedback regarding care and treatment by nursing staff.

This service was placed in special measures in November 2015. Improvements have been made such that a rating of requires improvement for the delivery of safe, caring and well led services and good for responsive and effective services. This led to an improved rating of requires improvement. I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by this service.

**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.

During our previous inspection in November 2015, we found concerns in areas relating to effective safeguarding referrals, medicines management, infection control and unactioned audits, fridge temperature recording, staff recruitment checks and records, staffing levels and relevant role specific training on safeguarding and basic life support.

At the inspection in August 2016, we found:

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were not fully assessed and well managed.
- The practice had not ensured that all recruitment checks had been completed.
- The policy for tracking blank prescription stationery was not being followed.
- Emergency medicines could be inaccessible if needed in an emergency.
- The business continuity plan and other policies were not comprehensive or reflected current guidelines.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services.

During our previous inspection in November 2015, we found concerns in areas relating to relevant role specific staff training, personal development plans for all staff and an induction programme and training for all newly recruited members of staff.

At the inspection in August 2016, we found:

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.

# Summary of findings

- Performance for osteoporosis related indicators was 100% compared to the local average of 81% and the national average of 81%.
- Performance for dementia related indicators was 100% compared to the local average of 96% and the national average of 95%.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was a system to identify when staff had received training and when it needed to be updated. Staff were given protected time to complete training.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

The practice held regular clinics designed to improve public health outcomes, including, contraception, travel and chronic disease clinics.

**Are services caring?**

**Requires improvement**

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

During our previous inspection in November 2015, we found concerns in areas relating to patient satisfaction with GP and nursing care.

At the inspection in August 2016, we found:

- Results from the national GP patient survey showed patients rated the practice comparable with or higher than others for some aspects of care. For example, 91% of patients said they find the receptionists at the surgery helpful (CCG average 81%, national average 87%). GP survey results were also lower than the CCG and national averages. We noted that satisfaction regarding nursing staff had decreased since the previous survey. The management team were aware of the results and had made changes to improve this, however it was too early to measure the impact that these changes had made.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible. Including leaflets in easy to read formats and other languages.

# Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

The number of patients who were registered as carers at the practice was lower than the census data, which outlines higher numbers of carers within this community.

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

**Good**

The practice is rated as good for providing responsive services.

During our previous inspection in November 2015, we found concerns in areas relating to the management of feedback from patients including complaints and concerns.

At the inspection in August 2016, we found:

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, they were involved in a project to offer appointments later in the evening and on weekends at an alternative practice.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care. Urgent appointments were 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff.

The surgery had completed building work to improve facilities for patients.

**Are services well-led?**

**Requires improvement**

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

During our previous inspection in November 2015, we found concerns in areas relating to the leadership, culture and governance arrangements within the practice. However, some improvements were still required.

At the inspection in August 2016, we found:

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

# Summary of findings

- There was a newly implemented leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. However, not all policies were fully comprehensive or up to date.
- Recruitment checks were in place but not all recruitment checks had been completed for all members of staff.
- There was an overarching governance framework. However, there were shortfalls in the governance arrangements relating to safety issues.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

There was a focus on continuous learning and improvement at all levels. All staff had received an appraisal.

# 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 provider was rated as requires improvement for safe and being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Care and treatment of older patients reflected current evidence-based practice. For example, do not attempt resuscitation orders were clearly documented.
- The practice identified older patients and coordinated the multi-disciplinary team for the planning and delivery of palliative care for patients approaching the end of life. The practice was aware of the gold standards framework for end of life care and knew how many patients they had who were receiving palliative care including a palliative care register.
- We saw unplanned hospital admissions and re-admissions care plan for the over 75's were regularly reviewed and improvements made.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older patients were higher than national averages. For example, 100% of patients aged 50 or over (and who have not attained the age of 75) with a fragility fracture and confirmed diagnosis of osteoporosis, were currently treated with an appropriate bone-sparing agent. This was higher when compared to the local clinical commissioning group average (96%) and national average (81%).

Immunisation campaigns for the elderly such as flu, shingles and pneumonia were advertised through posters, messages on prescriptions, website updates and letters, with follow up phone calls to those who have not attended.

### People with long term conditions

**Requires improvement**

The provider was rated as requires improvement for safe and being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The lead GP and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

# Summary of findings

- Performance for diabetes related indicators was 100% which was comparable to the clinical commissioning group (CCG) average of 91% and national average of 89%.
- Longer appointments and home visits were available when needed.
- All these patients had a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the lead GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice participates in the clinical commissioning group complex case management scheme which provides proactive care for those at highest risk of emergency admission.
- Long term condition review clinics were held by the practice nurses.
- Performance for chronic obstructive pulmonary disease (COPD, a collection of lung diseases including chronic bronchitis and emphysema) indicators showed the practice had achieved 100% of targets which was similar when compared to the CCG average (98%) and higher when compared to the national average (96%).
- The practice had employed a pharmacist to assist with chronic disease care, medicines management and medication reviews.

The practice hosted free chair yoga classes with a yoga teacher for those with long term conditions.

**Families, children and young people**

**Requires improvement**

The provider was rated as requires improvement for safe and being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances.
- Childhood immunisation rates for the vaccinations given was comparable to the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 80% to 100% (CCG average 75% to 95%) and five year olds from 76% to 96% (CCG average 81% to 93%).
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 81% and the national average of 82%.

# Summary of findings

- Appointments were available outside of school hours and the premises were suitable for children and babies. A pram storage area had been built to alleviate the space issues within the practice.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

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

Requires improvement

The provider was rated as requires improvement for safe and being 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 is open daily between 8am and 7pm Monday to Friday. The practice also participates in a scheme across Slough that provides evening and weekend GP appointments. These are available until 8pm each evening and from 9am-1pm on Saturdays and Sundays.
- The practice was proactive in offering online services for booking appointments and repeat prescriptions as well as a full range of health promotion and screening that reflects the needs for this age group.

**People whose circumstances may make them vulnerable**

Requires improvement

The provider was rated as requires improvement for safe and being 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 living in vulnerable circumstances including homeless patients, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice had completed 71% of learning disability health checks, which is above the national average of 44%.
- The practice had told vulnerable patients about how to access various support groups and voluntary organisations.
- GPs worked within a multi-disciplinary team to ensure the best outcomes for vulnerable patients.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

# Summary of findings

- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice advocates on behalf of homeless and other vulnerable patients in letter writing and securing support from other agencies.

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

Requires improvement

The provider was rated as requires improvement for safe and being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 93% of patients diagnosed with dementia that had their care reviewed in a face to face meeting in the last 12 months, which is higher than the local average of 85% and the national average of 84%.
- 93% of patients with a severe mental health issue who had a comprehensive, agreed care plan documented in the last 12 months, which was comparable to the local average of 89% and the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- Proactive dementia screening is undertaken for at risk patients.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results published in July 2016 showed the practice was performing in line with or above local averages. 455 survey forms were distributed and 96 were returned.

- 83% found it easy to get through to this surgery by phone compared to a CCG average of 50% and a national average of 73%.
- 91% found the receptionists at this surgery helpful compared to the CCG average of 81% and the national average of 87%.
- 77% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 80% and the national average of 85%.
- 87% said the last appointment they got was convenient compared to the CCG average of 85% and the national average of 92%.
- 73% described their experience of making an appointment as good compared to the CCG average of 58% and the national average of 73%.
- 58% usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 53% and the national average of 65%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 40 comment cards of which all were positive about the standard of care received. Comments from patients included friendly and courteous reception staff, ease of making appointments and how accessible, professional and approachable the GPs were. There were also many compliments around the cleanliness and building improvements made to the practice. Six comment cards gave a mixed view; describing long waits for appointments and difficulty booking a suitable appointment.

We spoke with nine patients during the inspection who said that they were happy with the care they received and thought that staff were approachable, committed and caring. Representatives of the patient participation group (PPG) told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

# Dr Veena Sharma

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team included an CQC inspection manager and a GP specialist advisor.

## Background to Dr Veena Sharma

Dr Veena Sharma provides primary medical services to approximately 4700 patients from a two storey converted house in Slough, Berkshire.

The local population has a high number of ethnic minority groups with a high proportion of these being non-English speakers. Overall, the combined localities score medium on the deprivation scale, indicating that many patients registered are affected by social deprivation. There are known areas of high deprivation locally within the practice boundary.

The practice is registered as a single GP provider and there are two locum GPs who undertake regular sessions. Other staff include one fulltime and one part time practice nurse, a small number of reception staff, a medical secretary and a practice manager.

Since the practice was inspected in November 2015 they have worked with the local clinical commissioning group (CCG), Royal College of General Practitioners (RCGP) and NHS England to ensure improvements are made. Dr Veena Sharma have recruited a new practice manager who has been in post for a short period of time.

The practice is open daily between 8am and 7pm Monday to Friday. The practice also participates in a scheme across Slough that provides evening and weekend GP appointments. These are available until 8pm each evening and from 9am-1pm on Saturdays and Sundays. Most of these consultations are with Dr Sharma. Patients may also see a doctor who is not from the practice but who has access (with consent) to the medical records. These additional slots can be booked through the practice reception in the usual way but appointments are delivered at Crosby House Surgery, 91 Stoke Poges Lane, Slough SL1 3NY.

The practice has opted out of providing out of hours GP services. This is offered to patients of the surgery via the NHS 111 service. Details are provided on the practice website.

When we carried out an inspection in November 2015 the practice was found to be in breach of four regulations of the Health and Care Social Act 2008. Enforcement action was taken in respect of these breaches in regulation.

Regulated activities are carried out at:

Dr Veena Sharma

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Slough

Berkshire

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## Why we carried out this inspection

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

# Detailed findings

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

The practice was previously inspected on the 26 November 2015 and was rated as inadequate for the safe and well-led domains. It was also rated as requires improvement for the provision of effective, caring and responsive services. The overall rating for the practice was inadequate and they were placed into special measures.

Following the November inspection, the practice was found to be in breach of four regulations of the Health and Care Social Act 2008. Requirement notices were set for the regulations relating to the management of medicines, infection control procedures, recruitment and supporting staff. Enforcement action was taken in relation to the regulation relating to good governance. There was not an effective operation of systems designed to regularly assess and monitor the quality of the services, to identify, assess and manage risks relating to the health, welfare and safety of patients and others who may be at risk.

## How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations, such as the Clinical Commissioning Group (CCG), to share what they knew.

Following the November 2015 inspection we asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting. Before visiting in August 2016 the practice confirmed they had taken the actions detailed in their action plan.

We carried out an announced visit on 30 August 2016. During our visit we:

- Spoke with a range of staff including two GPs, one practice nurse, administration and reception staff and a practice manager.
- We spoke with patients who used the service and representatives of the patient participation group (PPG)
- Observed how people were being cared for.
- Reviewed the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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)

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.

Requires improvement

# Are services safe?

## Our findings

During our inspection in November 2015, we identified significant concerns in relation to the safe domain. This included the poor investigation, action and learning from significant events; delayed safeguarding referrals; staff undertaking chaperone duties without an appropriate disclosure and baring service check; infection control audit actions not being completed; medicines management processes were not effective for fridge temperature and monitoring the administration of vaccinations. Recruitment checks were not in place and staff records were incomplete; staffing levels were identified as a risk with one GP covering the all GP appointments in the practice. We were also unable to identify which staff had received basic life support training and the business continuity plan was limited.

At the inspection in August 2016, we found improvement had been made. However, there were areas which required improvement.

**Safe track record and learning**

- When we visited the practice in November 2015 we found there was a system in place for reporting and recording significant events. However, the investigations and outcomes were not always well evidenced or implemented thoroughly enough. Since the last inspection progress has been made with the implementation of a system to share, record and implement learning from significant events. For example, a prescription tracking system was created when there was an incident of a prescription being lost.
- Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. We reviewed nine significant events from the preceding year and found that the significant events had been minuted when they had been discussed at meetings which took place monthly. Learning from these events was evident on the day of inspection.
- We reviewed national patient safety alerts and how these were disseminated amongst staff. For example, all safety and medicine alerts are emailed directly to the practice manager who decides what action, if any, is required and distributes to other staff accordingly. However, this was a new system and the practice was unable to provide evidence to demonstrate this was fully embedded and tested.

**Overview of safety systems and processes**

The practice had sufficient systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- Arrangements were in place to safeguard children and vulnerable adults from abuse required improvement. The practice policies reflected relevant legislation and local requirements and were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare and a list of contact numbers was listed in each clinical room and behind reception. We saw that although an adult safeguarding referral had been made the practice had not notified the Care Quality Commission (CQC), in line with their policy. The safeguarding children policy did not include the notification process to CQC.
- There was a lead member of staff for safeguarding. The lead GP attended safeguarding meetings when possible and engaged with external stakeholders. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The lead GP and locum GPs were trained to Safeguarding level three for children. One practice nurse was trained to safeguarding level two and one to level one. However, their understanding of safeguarding, how to identify and report concerns was good.
- A notice in the waiting room advised patients that some members of staff could act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring service check (DBS check). (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and all staff had received training.
- We saw evidence that an annual infection control audit had been undertaken, and action had been taken to address any improvements required.

Requires improvement

# Are services safe?

- The arrangements for managing medicines in the practice kept patients safe (including recording, handling, storing and security). The practice discussed prescribing compliance with the local CCG pharmacy teams.
- Vaccines were stored appropriately and in accordance with the practice policy.
- Prescription pads were securely stored and there was a logging system in place. However, the log was not completed to ensure their use was monitored. This was rectified soon after the inspection.
- Patient Group Directions (PGD's) had been adopted by the practice to allow nurses to administer medicines. PGD's were used in line with current guidance.
- We reviewed six personnel files and found evidence that improvements had been made in recruitment checks. A recruitment checklist had also been created to ensure the practice collated all of the recruitment information for newly employed staff. On the day of inspection, we found reference information and contracts missing for newly recruited staff. The practice had recognised that further improvements were required and a list of the missing information had been created. The practice was in the process of obtaining this information.

**Monitoring risks to patients**

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was tested to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella.
- Arrangements were in place to plan and monitor the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups, to ensure that enough staff were on duty. The practice have recently agreed that locum GPs will give their availability four weeks ahead to ensure that patients are offered advance appointments. On the day of inspection we saw this had been implemented for the following four weeks. The practice were actively recruiting another GP.

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

The practice had arrangements in place to respond to emergencies and major incidents.

- The practice had a business continuity plan in place for major incidents such as power failure or building damage, however, the information contained in this was limited. For example processes and procedures to ensure business continuity had not been considered for significant staff illness, bad weather and structural damage. The contact details for staff was missing.
- The practice were able to evidence that all staff had received annual basic life support training.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency and an emergency policy ensured staff followed the correct procedure for responding to and recording incidents.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- The emergency equipment was checked regularly, however, the oxygen cylinder was not physically tested to ensure it was fit for use. The equipment was not stored in one place to ensure accessibility and minimise any delay in an emergency.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

During our inspection in November 2015, we identified concerns in relation to the effective domain. This included a limited clinical audit programme and continuous improvement; staff training was incomplete and staff were not always supported through induction or appraisal.

At the inspection in August 2016, we found improvements had been made.

**Effective needs assessment**

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through a monthly review of the Quality and Outcomes Framework (QOF) data.

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

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available, with 11.1% exception reporting, which is higher than the Clinical Commissioning Group (CCG) average of 7.6% and national average of 9.2%. This practice was not an outlier for any QOF (or other national) clinical targets.

On the day of inspection the practice showed us that they currently have exception reported 12 patients. The GP specialist advisor reviewed the exception reporting of these 12 patients and found the reasons for exception to be genuine.

Data from 2014/15 showed;

- Performance for all diabetes related indicators was higher (100%) than the CCG (90.5%) and national (89.2%) averages.
- The percentage of patients with hypertension having regular blood pressure tests (100%) was comparable to the CCG (99.3%) and national (97.8%) averages.
- Performance for mental health related indicators (100%) was comparable to the CCG average (96.6%) and higher than the national average (92.8%).
- The dementia diagnosis rate (100%) was significantly above the CCG (82.4%) and national (81.5%) averages, with 0% exception reporting.

There was evidence of quality improvement including clinical audit.

- There had been six clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example, recent action taken as a result included, ensuring National Institute of Clinical Excellence (NICE) guidance was implemented for patients with osteoporosis to reduce the risk of fractures. There were three indicators audited with a national standard of 90% achievement for each indicator. Initially the practice were achieving 76%, 100% and 20%. Following targeted discussions with patients and further medicines being prescribed these figures were re audited and found to be 100%, 100% and 90%.

Information about patients' outcomes was used to make improvements such as, a CCG initiated monitoring of diabetes patients had led to an increase in screening for this patient group and helped the practice towards achieving its diabetes 100% QOF target.

**Effective staffing**

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the new practice nurse, who was an independent prescriber, was fully supported by the lead GP with all prescribing decisions until the practice felt that they had fully integrated into the role and practice policies.

Good

# Are services effective?

## (for example, treatment is effective)

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal, which included a development plan, within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. There was no evidence that staff had mental capacity act training. However, the practice had planned to provide this training to all staff in the coming months.

**Coordinating patient care and information sharing**

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a six monthly basis and that care plans were routinely reviewed and updated.

**Consent to care and treatment**

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, despite the lack of Mental Capacity Act 2005 training.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

**Health promotion and prevention**

The practice had a system in place to identify patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, those at risk of developing a long-term condition and those requiring advice on their diet, alcohol cessation and drug and substance misuse. Patients were then signposted to the relevant service. The lead GP had a special interest in drug and substance misuse and would offer patients support and information at the GP practice.
- The lead nurse completed NHS health checks for patients aged 40-74 years.
- In-house yoga sessions were available to patients and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 81% which was comparable to the CCG average of 80% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the

Good

# Are services effective?

## (for example, treatment is effective)

practice followed up women who were referred as a result of abnormal results. This involved the lead GP completing a monthly audit, although this was not recorded. The practice told us that they would ensure that the practice nurse would also complete a documented monthly check.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

- 32% of patients at the practice (aged between 60-69) had been screened for bowel cancer in the last 30 months; this was lower when compared to the CCG average (41%) and national average (58%).
- 58% of female patients at the practice (aged between 50-70) had been screened for breast cancer in the last 36 months; this was lower to the CCG average (62%) and the national average (72%).

As low uptake for bowel cancer screening had been identified the practice, in partnership with Macmillan Cancer, ensures they contact non-attenders to emphasise the importance of the screening and to encourage them to take advantage of the service. They also actively encouraged eligible patients to attend for breast cancer screening.

Childhood immunisation rates for the vaccinations given was comparable to the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 80% to 100% (CCG average 75% to 95%) and five year olds from 76% to 96% (CCG average 81% to 93%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where risk factors were identified.

Requires improvement

# Are services caring?

## Our findings

During our inspection in November 2015, we identified concerns in relation to the caring domain. This included poor patient survey results; a lack of translation services or information in other languages and the practice had identified a low number of carers.

At the inspection in August 2016, we found improvements had been made.

**Respect, dignity, compassion and empathy**

We observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was a patient complaint regarding confidentiality due to patients in the waiting area being able to hear telephone conversations at reception. Due to lack of space within the building improvements were difficult to implement.

40 patient CQC comment cards we received were positive about the service experienced, with six having some negative comments regarding getting an appointment. Patients we spoke to on the day said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

The practice had extra phone lines due for installation to improve telephone access and were in the process of ensuring that advance appointments would be available four weeks in advance and bookable online.

We also spoke with six members of the patient participation group. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Most comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

During the November 2015 inspection, results from the national GP patient survey showed patients felt they were not always treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with doctors and nurses.

At this inspection some of the results had improved or were similar to previous results. For example:

- 76% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89% (this was a 3% improvement on the previous patient survey).
- 90% said they had confidence and trust in the last GP they saw compared to the CCG average 92% and national average of 95% (this was an 8% improvement on the previous patient survey).
- 92% said they had confidence and trust in the last nurse they saw compared to the CCG average 93% and national average of 97% (this was a 3% improvement on the previous patient survey).
- 73% said the GP gave them enough time compared to the CCG average of 78%, and the national average of 87%.
- 71% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 84% and national average of 91%.

However, some of the results for satisfaction had decreased slightly. For example:

- 63% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 76% and national average of 85% (this was a 5% decrease on the previous patient survey).
- 66% said the last nurse they saw or spoke gave them enough time compared to the CCG average of 84%, and the national average of 92% (this was a 4% decrease on the previous patient survey).
- 68% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average 83% and national average of 91% (this was a 6% decrease on the previous patient survey).

The practice were aware of the low satisfaction with nurses and had responded to this. A new practice nurse was employed as lead nurse in May 2016. The patient participation group (PPG) had conducted an in house survey in July 2016. This survey was completed by 60 patients (1.25%). This survey found that that between 86%

and 98% of patients were satisfied with the care and treatment of the nurses (which is above the local and national averages). GP survey results were also lower than the CCG and national averages. We noted that satisfaction regarding nursing staff had decreased since the previous survey. The management team were aware of the results and had made changes to improve this, however it was too early to measure the impact that these changes had made.

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

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on 40 comment cards we received was also positive and aligned with these views. Other feedback included dissatisfaction with making appointments.

During the November 2015 inspection, results from the national GP patient survey showed patients responded negatively to questions about their involvement in planning and making decisions about their care and treatment. Results were below local and national averages.

At this inspection some of the results had improved while others had decreased slightly. For example:

- 74% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 78% and national average of 86% (this was a 2% improvement on the previous patient survey).
- 67% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 72% and national average of 81% (this was a 2% improvement on the previous patient survey).
- 71% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 82% and national average of 90% (this was a 3% decrease on the previous patient survey).
- 58% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to a CCG average of 76% and national average of 85% (this was an 8% decrease on the previous patient survey).

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

- Staff told us that many staff were bilingual and could offer in-house translation services for patients who did not have English as a first language. There were a number of languages spoken by varying staff members including Polish, Guajarati and Hindi. There was also an additional translation service in place if needed. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format and some were available in different languages.

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

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 32 patients as carers (0.67% of the practice list). Carers were identified at registration and during opportunistic appointments. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

During our inspection in November 2015, we identified concerns in relation to the responsive domain. This included poor patient survey results and complaints were not always identified, investigated thoroughly to ensure lessons were learnt and actions taken to improve services to patients.

At the inspection in August 2016, we found improvements had been made.

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

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice were involved in instigating the CCG practice pharmacist role through further investment.

- The practice offered appointments until 7pm Monday to Friday, for working patients who could not attend during normal opening hours. Evening appointments until 8pm and Saturday and Sunday morning pre-bookable appointments could be made at an alternative practice.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice had recently had building improvement work completed to improve patient facilities.
- Immunisation campaigns for the elderly such as flu, shingles and pneumonia were advertised through posters, messages on prescriptions, website updates and letters, with follow up phone calls to those who have not attended.
- The practice had a pharmacist to assist with chronic disease care, medicines management and medication reviews.
- The practice hosted free chair yoga classes with a yoga teacher for those with long term conditions.
- The practice held a register of patients living in vulnerable circumstances including homeless patients, travellers and those with a learning disability. The practice staff acted as advocates on behalf of homeless and other vulnerable patients in letter writing and securing support from other agencies.

**Access to the service**

The practice was open daily between 8am and 7pm Monday to Friday. The provider offered extended hours from another practice until 8pm every weekday evening and on Saturday and Sunday mornings (which were booked as usual via the main reception). In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for patients that needed them. The practice were implementing a new system with locum GP availability to enable patients to book up to four weeks in advance but this was not yet available on the day of inspection.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was similar to local and national averages. This had improved from the previous national survey results. Patients told us on the day that they were able to get appointments when they needed them.

- 64% of patients were satisfied with the practice's opening hours compared to the CCG average of 69% and national average of 75%
- 83% patients said they could get through easily to the surgery by phone compared to the CCG average of 48% and national average of 73%
- 73% patients described their experience of making an appointment as good compared to the CCG average of 55% and national average of 73%
- 58% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 51% and national average of 65%

Satisfaction with the practice's opening hours had decreased. The practice offers appointments until 8pm every weekday evening and on Saturday and Sunday morning at an alternative practice (which is often covered by the lead GP). Since the survey the practice has proactively encouraged patients to access this service, which had resulted in an increase in appointments offered.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns.

- The practice complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, with notices in the waiting room and details on the practice website.

We looked at nine complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, when two referrals went missing the practice implemented a referral tracking system to mitigate the risk of this occurring again.

# Are services well-led?

Requires improvement

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

## Our findings

During our inspection in November 2015, we identified significant concerns in relation to the well led domain. This included ineffective governance processes and systems; a lack of business planning and future strategy; policies were not updated; staffing levels in the practice meant patients did not always receive a responsive service; clinical audits were not effective and demonstrated limited clinical improvement. Staff were not always receiving training or support through appraisals.

At the inspection in August 2016, we found improvement had been made. However, there were areas which required improvement.

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values.
- The practice had identified further areas for improvement and had plans in place to continue with the changes in order to offer improved services to patients. This included a new room to offer phlebotomy services.

**Governance arrangements**

The practice had made significant improvements to their governance framework to support the delivery of the strategy and good quality care. However, the new improvements and the effectiveness were difficult to evidence due to the short time since implementation. The governance framework outlined the structures and procedures in place however, improvements were required:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. Some policies required updating. For example the safeguarding children and complaints policy.
- The practice demonstrated a comprehensive understanding of the performance of the practice.
- A programme of clinical and internal audit was implemented to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, risks were not fully assessed and well managed. For example, emergency medicines and equipment could be inaccessible if needed urgently and the practice had not ensured that recruitment checks had been completed for all staff. The system to track prescriptions through the practice had only been implemented the day before the inspection and we were unable to test the effectiveness.

**Leadership and culture**

The leadership team was newly formed as the practice manager had joined the practice a few weeks before the inspection. The GP and practice manager had worked together to identify the areas where further improvements were required. At the time of inspection, these were in the process of being implemented or plans were in place for the improvements to be made in the future.

The leadership team in the practice told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. Staff told us that although the past few months had been a time of change and uncertainty that they felt improvements had been made since the practice manager was in post.

The practice had a vision and strategy to increase the size of their practice and expand clinical provision, which was in place at this inspection. Staff we spoke with were clear about their responsibilities. They enjoyed working at the practice and felt supported by the practice management.

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

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology

# Are services well-led?

Requires improvement

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

- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings and minutes were recorded.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the leadership team encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The practice had sought feedback from staff and patients and had investigated the outcomes to identify where areas of improvement could be made. Staff members had received performance reviews to identify training or development needs.

The practice had a system in place for knowing about notifiable safety incidents. However, as this system was new there was limited evidence to show that it was fully embedded within the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and carried out patient surveys. The PPG were very engaged with the inspection process and demonstrated enthusiasm to support the practice to deliver a high quality service. The most recent survey they carried out was completed by 60 patients and found that that between 86% and 98% of patients were satisfied with the care and treatment of the nurses (which is above the local and national averages).
- The practice had gathered feedback from staff through meetings, discussions and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

**Continuous improvement**

There was a new focus on continuous learning and improvement at all levels within the practice. The practice team were becoming forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, extending appointments by working with another practice to offer later and weekend appointments.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>How the regulation was not being met:<br>• The provider did not evidence that governance systems were fully embedded and followed by staff.<br>• The provider did not ensure that emergency medicines were accessible if needed urgently.<br>• The provider did not ensure that all practice policies were up to date and reflected current standards.<br>• Risks to patient safety were not fully assessed and well managed.<br>The business continuity plan did not ensure the practice would be able to maintain services in an emergency or during an event which impacts on the level of service. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>How the regulation was not being met:<br>• The provider did not ensure that nursing staff were appropriately trained in safeguarding children level two, to enable them to carry out the duties they are employed to perform. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>How the regulation was not being met:<br>• The provider had not ensured that recruitment checks had been fully completed for all members of staff. |