Clover Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Requires Improvement overall. The practice was previously inspected on 10 December 2014 when the service was rated as Good overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Requires improvement

Are services responsive? – Requires improvement

Are services well-led? - Requires improvement

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Requires improvement

People with long-term conditions – Requires improvement

Families, children and young people – Requires improvement

Working age people (including those retired and students – Requires improvement

People whose circumstances may make them vulnerable – Requires improvement

People experiencing poor mental health (including people with dementia) - Requires improvement

We carried out this announced comprehensive inspection at Clover Health Centre on 22 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. However, minutes of meetings where incidents were discussed, were not sufficiently detailed to ensure learning was shared effectively with all staff.
- Staff we spoke to knew how to identify and report safeguarding concerns. However, not all staff had received up-to-date safeguarding training appropriate to their role, including the safeguarding lead who did not have training in adult safeguarding.
- The practice did not keep records of essential training for all staff, such as training in fire safety, infection control and safeguarding.

Summary of findings

- There were procedures in place to manage infection prevention and control; however, there was no cleaning schedule in place against which cleaning standards were monitored.
- There was a system for receiving and acting on safety alerts, such as those provided by MHRA (Medicines and Healthcare products Regulatory Agency). However, the system in place was not sufficient to guarantee appropriate action was always taken when required.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, some PGDs had not been signed by all relevant staff.
- The most recent published Quality and Outcomes Framework (QOF) results (2016/17) showed the practice performance rates for a number of indicators were below the local clinical commissioning group (CCG) and national average.
- The practice's uptake rate for cervical screening was 62%, which was below the CCG average of 79% and national average of 81%.
- The results from the annual national GP patient survey published in July 2017 showed that patients did not feel they were always treated with care and concern. Practice satisfaction scores were below average for most indicators regarding consultations with GPs and nurses.
- The practice had identified only 10 patients as carers (0.16% of the practice list).
- Results from the annual national GP patient survey published in July 2017 showed that patients' satisfaction with how they could access care and treatment was below the local clinical commissioning group (CCG) and national averages. This was supported by comments from patients on the day of the inspection.
- Structures, processes and systems to support the management of good governance were in place and generally understood but procedures were not always formalised.
- The practice did not have an active patient participation group.

There are areas where the provider **must** make improvements, as they are in breach of regulations:

- The provider must ensure that persons employed in the provision of regulated activities receive the appropriate training to enable them to carry out their duties.
- The provider must improve patient outcomes by implementing a clinical quality improvement programme which includes monitoring performance against the Quality and Outcomes Framework.
- The provider must review the results of patient surveys in order to identify and implement the necessary action required to improve patient satisfaction.
- The provider must ensure that there is an effective procedure in place for the processing of patient safety alerts, such as those produced by the Medicines and Healthcare products Regulatory Agency (MHRA).
- The provider must ensure Patient Group Directions (PGDs) are signed by all relevant personnel.

The areas where the provider **should** make improvements are:

- The provider should revise their process for recording minutes for significant event analysis meetings to include all relevant details to ensure learning and necessary improvements are identified and shared with all staff.
- The provider should monitor cleaning standards on a regular basis.
- The provider should continue to monitor the practice uptake rate for cervical screening to make improvements as appropriate.
- The provider should review the effectiveness of policies and procedures and monitor adherence to systems and processes.
- The provider should review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to all carers registered with the practice.

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

Summary of findings

The six population groups and what we found

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

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

Clover Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector**.** The team included a GP Specialist Advisor and an Expert by Experience.

Background to Clover Health Centre

Clover Health Centre began operating in 2011 delivering GP services under an Alternative Provider Medical Services (APMS) contract. (APMS contracts allow NHS England to contract with a provider under local commissioning arrangements specific to that service). Until October 2016 the service was also providing a GP Walk-in service.

The service is registered with the CQC as an Organisation under the parent company Greenwich Primary Care Collaborative which is a Community Interest Company (CIC). (A CIC is a type of company designed for social enterprises. In line with the organisational requirements of a CIC the profits are reinvested in the company for the good of the community.) The service is registered with the CQC to provide the regulated activities of maternity and midwifery services; diagnostic and screening procedures and treatment of disease, disorder and injury.

Clover Health Centre is based in Equitable House, 10 Woolwich New Road SE18, a building shared with several other businesses, located in the centre of Woolwich opposite Woolwich Arsenal station. The practice is based on the first floor of the building (served by a lift) with all areas occupied by the practice being on one level. The service is located in the Royal Borough of Greenwich. Greenwich Clinical Commissioning Group (CCG) is responsible for commissioning health services for the locality.

The accommodation includes five consulting/treatment rooms and an isolation room and four further consulting/ treatment rooms which are used to host other community services, such as diabetic eye screening and physiotherapy. There is a reception desk with administration area and practice manager's office behind and two separate waiting areas. Staff amenities, including kitchen and rest area, are also on the same floor.

The practice has a steadily increasing patient population of 5,800 registered patients. The practice age distribution differs from the national average with a much higher than average number of patients in the 20 to 39 year age group and a much lower number of patients aged over 50 years (96% of the patient population are under 65 years). The surgery is based in an area with a deprivation score of 3 out of 10 (with 1 being the most deprived and 10 being the least deprived).

GP services are provided by one full-time male lead GP (salaried), providing six clinical sessions a week and one male long-term locum GP providing seven clinical sessions a week.

Clinical services are also provided by four practice nurses (3.34 wte) and a part-time health care assistant.

Administrative services are provided by the Practice Manager (1 wte) and six administration/reception staff (4.63 wte).

The service is open from 8am to 6.30pm Monday to Friday and from 9am to 1.30pm on Saturday.

Requires improvement

Are services safe?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing safe services.

The practice was rated as requires improvement for providing safe services because:

- Some staff had not received up-to-date safeguarding training appropriate to their role, including the safeguarding lead who did not have training in adult safeguarding.
- There was no cleaning schedule in place against which cleaning standards were monitored.
- Minutes of meetings where incidents were discussed with staff were not sufficiently detailed to ensure learning was effectively shared with all staff.
- Some Patient Group Directions (PGDs) required signing by relevant staff.
- The system in place for MHRA (Medicines and Healthcare products Regulatory Agency) alerts was not sufficiently effective to ensure appropriate action was always taken when required.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had safety policies and procedures which were regularly reviewed and readily available to staff. Staff received safety information for the practice as part of their induction.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff were aware of the need to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks at recruitment and on an ongoing basis, including checks of professional registration where relevant. Disclosure and Barring Service (DBS) checks were undertaken annually for all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff we spoke to knew how to identify and report safeguarding concerns. However, not all staff had received up-to-date safeguarding training appropriate to their role, including the safeguarding lead who did not have adult safeguarding training. Contact details for safeguarding referral services were available in all consultation rooms.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There were procedures in place to manage infection prevention and control; however, there was no cleaning schedule in place against which cleaning standards were monitored.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing clinical waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- When there were changes to services or staff, the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all necessary information.

Requires improvement

Are services safe?

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, oxygen and emergency medicines and equipment minimised risks. The practice stored prescription stationery securely and monitored its use.
- Staff prescribed and administered medicines and gave advice to patients in line with legal requirements and current national guidance.
- The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up appropriately. The practice involved patients in regular reviews of their medicines. The practice had undertaken a medicines use review for all patients receiving 15 or more medicines on repeat prescription.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, some PGDs had not been signed by all relevant staff. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)

Track record on safety

The practice had a good safety record.

- There were appropriate risk assessments in relation to safety issues.
- The practice monitored and reviewed activity in order to understand risks and identify required safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Management supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. However, minutes of meetings where incidents were discussed with staff were not sufficiently detailed to ensure learning was effectively shared with all staff.
- There was a system for receiving and acting on safety alerts, such as those provided by MHRA (Medicines and Healthcare products Regulatory Agency). However, the system in place for was not sufficiently effective to ensure appropriate action was always taken when required.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice overall, and across all population groups, as requires improvement for providing effective services.

The practice was rated requires improvement for providing effective services because:

- The most recent published Quality and Outcomes Framework (QOF) performance rates for many indicators were below the local clinical commissioning group (CCG) and national average. The 2016/17 results showed the practice achieved only 76% of the total number of points available compared with the clinical commissioning group (CCG) average of 93%
- The practice's uptake rate for cervical screening was 62%, which was below the CCG average of 79% and national average of 81%.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. Clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance, supported by clear clinical pathways and protocols.

- Patients' needs were assessed, including their clinical needs and mental and physical wellbeing.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group was comparable with the local and national average.
- Antibacterial prescribing was comparable to local and national averages. In 2015/16 the percentage of antibiotic items prescribed that were Cephalosporins or Quinolones was 1.47%, compared to the CCG average of 3.54% and national average of 4.71%.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support if required.

Older people:

- Older patients who are frail or may be vulnerable were offered an annual assessment of their physical, mental and social needs.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any additional or changed needs.
- The practice had recently taken on the shared responsibility for providing GP services to three local care homes (approximately 206 patients). The practice nurse was the lead for this service and carried out twice weekly visits to each home.

The 2016/17 Quality and Outcomes Framework (QOF) performance rates for many of the conditions found in older people such as, COPD and heart failure were below the local clinical commissioning group (CCG) and national average. For example,

- The practice performance rate for COPD (chronic obstructive pulmonary disease) was 82% (CCG average: 93%, national: 96%).
- The practice performance rate for heart failure was 78% (CCG average: 96%, national: 98%).

People with long-term conditions:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and practice nurses worked with other health and care professionals to deliver a coordinated package of care.
- Staff with specialist knowledge of specific long-term conditions were responsible for reviews of patients with those conditions. Staff had received specific training for the role.

The 2016/17 Quality and Outcomes Framework (QOF) performance rates for many long-term conditions such as, diabetes, asthma and hypertension were below the local clinical commissioning group (CCG) and national average. For example, the practice performance rates for:

- diabetes related indicators was 56% (CCG average: 85%, national: 91%).
- asthma related indicators was 71% (CCG average: 96%, national: 97%).
- hypertension was 72% (CCG average: 95%, national: 97%).

Requires improvement

Are services effective?

(for example, treatment is effective)

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given in 2015/16 were below the target percentage of 90%. The practice were aware of this and had taken action to improve immunisation uptake.They reported that in 2016/17 they had achieved the 90% target rate for the 5 in 1 vaccine. (The 5 in 1 vaccine is the DTaP/IPV/Hib, Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Vaccine, Hib (Haemophilus influenzae type b)).

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

- The practice's uptake for cervical screening was 62%, which was below the CCG average of 79% and national average of 81%. The practice was aware of this and had taken action to improve their screening rates. They had engaged with Public Health Greenwich to appoint a representative from the local Somalian and African community to promote the importance of regular screening and had introduced Saturday morning appointments for working women. This had resulted in an improvement to uptake rates in the current year.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those patients whose circumstances may make them vulnerable. Meetings were arranged with the palliative care team on a patient specific basis when required.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had a higher than average number of patients who were registered as homeless and held weekly housing status update meetings with the housing officer.

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

- 75% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable to the CCG and national average of 84%.
- 88% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to the CCG average of 84% and national average of 90%.
- The practice considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received a discussion and advice about alcohol consumption was 97% compared to the CCG average of 84% and national average of 91%. The percentage of patients who had received a discussion and advice about smoking cessation was 94% (CCG average 94% and national average 95%).

Monitoring care and treatment

The practice routinely reviewed the effectiveness and appropriateness of the care provided. For example, they had recently undertaken a medicines review for all patients receiving 15 or more medicines on repeat prescription and clinicians took part in local and national improvement initiatives, such as the Year of Care (YoC) programme. (YoC is about improving care for people with long-term conditions by supporting them to self-manage their condition).

The practice had recently introduced a programme of quality improvement activity in response to their below average Quality and Outcomes Framework (QOF) performance rates for 2016/17. The most recent published QOF results showed the practice had achieved 76% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 95%. The clinical exception reporting rate of 8% was comparable to the CCG average of 8% and national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Requires improvement

Are services effective?

(for example, treatment is effective)

The overall QOF performance rates had improved significantly from the 54% achieved in 2015/16 but the practice were aware of the need to continue to improve performance rates and had implemented quality improvement strategies to address this.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning requirements of staff and provided protected time and training to meet their needs. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- All appropriate staff were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients and carers to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the individual needs of patients, including those who may be vulnerable because of their circumstances. Meetings were arranged with the multi-disciplinary team when required on a patient specific basis.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives and patients at risk of developing a long-term condition. Carers were offered annual flu vaccination.
- New cancer cases referred using the urgent two week wait referral pathway data were comparable with the local and national average.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. Staff informed us they used the principles of care acquired through the Year of Care training to assist patients to self-manage long-term conditions.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Requires improvement

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing caring services.

The practice was rated as requires improvement for caring because:

- The results from the annual national GP patient survey published in July 2017 showed patients did not feel they were always treated with care and concern. The practice satisfaction rates were below average for most indicators regarding consultations with GPs and nurses.
- The practice had identified only 10 patients as carers (0.16% of the practice list).

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff considered patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 24 Care Quality Commission comment cards we received were positive about the service experienced. Patients commented that they provided a friendly, caring and efficient service. This was in line with the results of the NHS Friends and Family Test (FFT) and other feedback received by the practice. For example, the results of the previous three months FFT showed that more than 86% of patients would recommend the service to others.

However, results from the July 2017 annual national GP patient survey showed patients did not feel they were always treated with care and concern. There were 358 surveys sent out and 98 were returned. This represented 1.6% of the practice population. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 77% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 71% of patients who responded said the GP gave them enough time; CCG - 82%; national average - 86%.
- 83% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 94%; national average - 95%.
- 69% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG – 80%; national average - 86%.
- 83% of patients who responded said the nurse was good at listening to them; CCG - 86%; national average - 91%.
- 76% of patients who responded said the nurse gave them enough time; CCG - 87%; national average - 92%.
- 87% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 95%; national average - 97%.
- 77% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 86%; national average - 91%.
- 67% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

The provider had considered the results of the 2016/17 GP Patient Survey but had not reviewed the results related to consultations with GPs and nurses and had therefore not implemented any strategies for improvement in this area.

Involvement in decisions about care and treatment

Staff encouraged patients involvement in decisions about their care and treatment and were aware of the need to make sure that patients and their carers could access and understand the information they were given:

- For patients who did not have English as a first language, interpreting services were available through the language line telephone service or an interpreter could be booked in advance through the local council. There were notices in the reception area in several languages, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- A double appointment was allocated to patients who required an interpreter.
- Staff communicated with patients in a way that they could understand, for example, communication aids such as a hearing loop were available.

Requires improvement

Are services caring?

- Staff helped patients and their carers find further information and access community and advocacy services.

The practice identified patients who were carers. The practice computer system alerted staff if a patient was also a carer. The practice had identified only 10 patients as carers (0.16% of the practice list).

Staff told us that if families had experienced bereavement they would be contacted if known to the practice and offered a patient consultation at a flexible time and location to meet their needs and advice was given on accessing support services if required.

Results from the national GP patient survey showed that patients mostly responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local clinical commissioning group (CCG) and national averages:

- 80% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 67% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 78%; national average - 82%.
- 81% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 85%; national average - 90%.
- 76% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 80%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of considering patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services.

The practice was rated as requires improvement because:

- Results from the annual national GP patient survey published in July 2017 showed that patients' satisfaction with how they could access care and treatment was below the local clinical commissioning group (CCG) and national averages. This was supported by comments from patients on the day of inspection.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended opening hours were provided on a Saturday morning for working patients..
- Online services were available for ordering repeat prescriptions and booking appointments. This was accessed via the NHS Choices website as the practice did not have a website.
- The practice improved services where possible in response to unmet needs.
- The rented premises and facilities were appropriate for the services delivered and accessible for wheelchair users, including a lift which had dual power to enable it to be battery operated if required.
- The practice made reasonable adjustments when patients found it hard to access services. The practice had identified that the largest ethnic groups in the patient population was Eastern European (52%) and Nigerian (30%) and had engaged with the local communities to ensure that appropriate support was available when required.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they chose to live.
- The provider had recently accepted responsibility for the provision of primary medical services to three care homes. One of the nurse practitioners, with a special interest in end of life care, had lead responsibility for the service and carried out two visits each week to the homes.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Clinical staff also accommodated home visits for those who had difficulties getting to the surgery.

People with long-term conditions:

- Patients with a long-term condition were offered an annual review to check their health and medicines needs were being appropriately met. However, attendance rates for annual reviews were low. Consultation times were flexible to meet patients specific needs.
- The practice held regular meetings with local multi-disciplinary team members to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- There were systems to identify and follow up children who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours appointments were available on a Saturday morning including nurse appointments for cervical smears.
- The practice staff could book extended hours appointments for patients with the local GP Alliance Hub service. These appointments were available on weekday evenings and at weekends. The service was staffed by GPs from the practices who were members of the alliance and full access to GP electronic records was available for consultations.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice liaised regularly with the local council housing team regarding patients identified as homeless.
- All patients on the practice learning disability register had received an annual review.

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

- Staff we interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice had collaborated with the Beresford Project in a programme to manage patients on long-term benzodiazepines (a type of medicine known as tranquilisers) The practice had reduced the number of patients taking the medicine from 22 to 8. (The Beresford Project provides support and advice to adult drug and alcohol users who want to be substance-free).

Timely access to the service

Patients we spoke to told us they sometimes found it difficult to access care and treatment from the practice within an acceptable timescale.

- Urgent appointments were generally available, providing timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. Patients we spoke to told us that appointments generally ran to time. However, results from the GP patient survey did not support this view.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the annual national GP patient survey published in July 2017 showed that patients' satisfaction with how they could access care and treatment was below the local clinical commissioning group (CCG) and national averages. This was supported by comments from patients on the day of inspection. There were 358 GP patient surveys sent out and 98 were returned. This represented a response rate of 27% (national average 38%) which was 1.6% of the practice population.

- 75% of patients who responded were satisfied with the practice opening hours compared with the CCG average of 79% and the national average of 80%.
- 46% of patients who responded said they could get through easily to the practice by phone; CCG average – 70%; national average - 71%.
- 49% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 69%; national average - 75%.
- 59% of patients who responded said their last appointment was convenient; CCG - 76%; national average - 81%.
- 49% of patients who responded described their experience of making an appointment as good; CCG - 69%; national average - 73%.
- 33% of patients who responded said they don't normally have to wait too long to be seen; CCG - 51%; national average – 58%.

The practice leadership were aware that the patient satisfaction rates regarding access to appointments was low. This had been discussed at a recent board meeting and the following suggestions had been made to address the issues:

- A short pre-recorded introductory message was incorporated in the existing welcome message informing patients that the walk in service previously provided by the practice had been discontinued as it was felt this may have influenced patients' expectations regarding access to appointments.
- Two additional incoming lines were installed so that back office staff could receive and action phone calls thereby increasing capacity.
- The availability of web booked appointments was increased so that patients who had online access could book appointments without having to call the practice.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Information about how to make a complaint or raise concerns was available and it was a simple process. Patients who made complaints were treated compassionately by staff.
- The complaint policy and procedures were in line with recognised guidance. Four complaints were received in the last year. We reviewed these complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends and took action to improve the quality of care. For example, patients had complained about the attitude of reception staff. This was discussed with reception staff who suggested that this may be due to the fact that they were performing too many simultaneous tasks. As a result, two receptionists were allocated to the front desk at peak times. No further negative comments had been received.

Are services well-led?

Requires improvement

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

Our findings

We rated the practice, and all of the population groups as requires improvement for providing a well-led service.

The practice was rated as requires improvement because:

- The leadership must implement an effective clinical quality improvement programme to improve clinical outcomes for patients.
- The leadership must ensure the results of patient surveys are reviewed in order to identify and implement the necessary action required to improve patient satisfaction.
- The leadership must ensure all staff receive the required training appropriate to their role.
- The leadership must ensure that effective procedures are in place to minimise risks to patient safety.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The lead GP was the Local Medical Director (LMD) for the service. They had the experience, capacity and skills to deliver the practice strategy and address risks. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The LMD was required to provide a service performance and update report at bi-monthly board meetings.
- Staff told us that the management team were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external stakeholders.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. Patients were fully involved in investigations and informed of investigation findings.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- All staff were considered valued members of the practice team. Clinical staff were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and management.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support the management of good governance were in place and

Are services well-led?

Requires improvement

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

generally understood but procedures were not always formalised. For example, the recording of minutes for significant event analysis meetings did not include all relevant details to ensure learning and necessary improvements were identified and shared with all staff.
- The governance and management of joint working arrangements promoted co-ordinated person-centred care.
- Staff were clear on their roles and responsibilities including in respect of safeguarding and infection prevention and control. However, the practice did not have evidence that all staff had received training in these areas appropriate to their role.
- The practice had established policies and procedures to ensure safety and to assure the organisations management team that they were operating as intended.

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance.
- The practice management had oversight of patient safety alerts, incidents and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information, combined with the views of patients and staff, was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings and all staff had sufficient access to this information.
- The practice management were required to report on performance information which was monitored and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. Plans were developed to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. The practice had appointed an experienced IT lead.
- The practice submitted data and notifications to external organisations as required. The practice provided services under an APMS (Alternative Provider medical services) contract and were therefore required to achieve and report on specific monthly KPIs (key performance indicators).
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The practice did not have an active patient participation group but were in the process of encouraging the recruitment of new members.
- The service was transparent and collaborative with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example, staff had identified concerns regarding the practice registration process. As a result the IT lead had implemented a training programme for staff to enhance their data input skills.
- The lead GP had recently completed training in order to become a teaching practice for medical students.

Are services well-led?

Requires improvement

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

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. However, this process was not always sufficiently detailed to ensure learning was shared with all staff.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** • The provider must review the results of patient surveys in order to identify and implement the necessary action required to improve patient satisfaction. This was in breach of Regulation 9 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The provider must ensure there is an effective procedure in place for the processing of patient safety alerts, such as those produced by the Medicines and Healthcare products Regulatory Agency (MHRA). • The provider must ensure that Patient Group Directions (PGDs) are signed by all relevant personnel. This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • The provider must ensure that all staff receive the required training appropriate to their role. This was in breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	• The provider must improve clinical outcomes for patients by implementing a clinical quality improvement programme and monitoring performance against the Quality and Outcomes Framework. This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.