

# Churchill Medical 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

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of the Churchill Medical Practice on 10 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well led services. The service was rated as requires improvement for providing a safe service. It was also good for providing services to older people, those with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances make them vulnerable and those people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Clinical audit cycles had been carried out, and we saw evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments.
- The practice had a number of policies and procedures to govern activity.

The areas where the provider must make improvements are:

- Undertake an audit to address any issues with cleaning. Ensure cleaning schedules are produced and available for inspection within the practice;

# Summary of findings

In addition the provider should:

- Ensure all significant event forms are fully completed and actions from significant event meetings are fully documented.

- Produce a centralised practice training log.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibility to raise concerns and report incidents and near misses. Significant events were recorded but not all actions taken were recorded on the form. Although risks to patients who use the services were assessed, the systems and processes to address the risks were not implemented well enough to ensure patients were kept safe. This included ensuring cleaning schedules or cleaning audits (we found that areas of the practice were not cleaned to an appropriate standard) were in place to check the work of the employed cleaning company. There was enough staff to keep patients safe.

Requires improvement



### Are services effective?

The practice is rated as good for effective as there are areas where it should make improvements. Data showed patient outcomes were above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was routinely referenced and used. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff received appropriate training for their roles and further training had been identified. The practice had good relationships with other health services. Multidisciplinary meetings were documented, although we noted that the meetings were taking place on a less frequent basis. The practice was able to demonstrate that audit cycles, where changes had been implemented and improvements made, had been completed.

Good



### Are services caring?

This practice is rated as good for caring. Data showed that the practice rated higher than others in the local area for several aspects of care. For example 86% of patients said that the GP's were good at listening to them. Patients said they were treated with compassion, dignity and respect and that they were involved in treatment decisions. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. The practice had an active Patient Participation Group (PPG) which met on a monthly basis to discuss practice concerns, develop the patient survey and organise wider community events.

Good



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

The practice is rated as good for responsive. The practice reviewed the needs of the local population and engaged with the local Clinical Commissioning Group (CCG) to secure service

Good



# Summary of findings

improvements, where these were identified. Patients told us that there was a long wait to see a named GP. Patients were able to make an appointment with the duty doctor if an earlier appointment was available in order to reduce the waiting time to see a GP. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a suitable complaints system with evidence demonstrating the practice responded quickly to issues raised. There was evidence of that learning from complaints was shared with staff.

## Are services well-led?

The practice is rated as good for well-led. The practice had a strategy for delivering services for the future. The practice had a number of governance policies and procedures and governance is discussed in regular practice meetings. There were systems in place to monitor and improve quality. We found that the practice did not maintain a risk register. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active Patient Participation Group (PPG). Staff received performance reviews and attended staff meetings.

Good



# Summary of findings

## What people who use the service say

We spoke with ten patients at the practice and collected 37 comment cards left by the CQC etc. that had been completed by patients prior to the inspection.

Patients were happy with the service that was provided. They told us they felt respected by the staff and they were listened to and involved in treatment decisions. Some raised concerns over the time taken to receive an appointment and the length of waiting time once at the practice.

We reviewed the national GP Patient Survey for 2014. We saw that 83% of patients who completed the survey would recommend the practice to someone moving into the area. This was considerably higher than the Clinical Commissioning Group (CCG) average of 68%. The survey also showed that 88% of patients considered their overall

experience of the practice to be good. This was also higher than the CCG average of 76%. Areas in which the practice had poorer scores included 36% of patients getting to see or speak to their preferred GP, compared to the CCG average of 53%. The latest patient survey undertaken by the practice's patient participation group showed that patients were happy with the service received.

The main concern that was raised by patients we spoke to was over the length of wait to see a GP, longer if they wished to see their named GP and the waiting time at the surgery. The practice was addressing these issues by providing catch up times within GP sessions and providing a duty doctor service.

## Areas for improvement

### Action the service **MUST** take to improve

- Undertake an audit to address any issues with cleaning. Ensure cleaning schedules are produced and available for inspection within the practice;

### Action the service **SHOULD** take to improve

- Ensure all significant event forms are fully completed and actions from significant event meetings are fully documented.
- Produce a centralised practice training log.

# Churchill Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP specialist advisor and practice manager. Both advisors had the same authority to enter registered persons' premises as the CQC Lead Inspector.

## Background to Churchill Medical Centre

Churchill Medical Centre is a teaching practice located in the London Borough of Waltham Forest. The practice is part of the NHS Waltham Forest Clinical Commissioning Group (CCG) which is made up of 45 practices. The practice currently holds a General Medical Services (GMS) contract and provides NHS services to 14,291 patients. The practice serves a diverse population, with many patients whose first language is not English. The age of the patient population is mixed with 37% under 18 years of age and 22% over the age of 65. The practice has a staff team that comprises 14 GP's (7 male and 7 female), 6 nurses, 2 healthcare assistants and a small team of reception/administrative staff. The practice operates from two sites, at 1 Churchill Terrace and at Ching Way Medical Centre, which was not inspected at this time. The practice is open between 8am and 6.30pm on Tuesday to Friday and has extended hours on Monday opening between 6.30pm and 8pm. The practice opted out of providing an out of hour's service and refers patients to the local out of hour's provider.

The practice is situated in its own premises at 1 Churchill Terrace, which consists of two floors. Consulting rooms are available on both floors and there is a lift to allow access for those with reduced mobility.

The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and the treatment of disease, disorder or injury.

The practice provides a range of services including child health surveillance, maternity services, cytology and childhood immunisations. The practice also offers a weight management clinic, smoking cessation and clinics for patients with long term conditions.

The CQC intelligent monitoring placed the practice in band five. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice, this only comes after a CQC inspection has taken place.

## 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. This 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.

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

## How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 November 2014. During our visit we spoke with a range of staff including GP's, practice nurse, the practice manager and reception staff. We spoke with patients who used the service and members of the Patient Participation Group. We reviewed 37 completed Care Quality Commission comments cards where patients and members of the public shared their views and experiences of the service.



# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts were used, as well as complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns and knew how to report incidents and near misses. For example, an incident occurred where a blank prescription pad was stolen from an unlocked consultation room. The practice was alerted by the pharmacist when a prescription form from the pad had been handed in for processing at the pharmacy without a GP signature. The practice completed a significant events form, alerted the police and put in place a process of locking consultation rooms when not in use.

### Learning and improvement from safety incidents

We reviewed safety records, incident reports and minutes of meetings where incidents and events were discussed for the last two years. This showed the practice had managed these consistently over time and could show evidence of a safe track record.

The practice had systems for reporting, recording and monitoring significant events and incidents. We reviewed records of significant events that had occurred during the last two years. The significant event forms contained details of the event, notes of the review meetings and the actions that were taken. For example a patient was unwell in the nurse's room following a travel vaccination and the nurse required assistance. The internal warning alarm was pressed but no assistance came as reception staff thought that it was a false alarm. The matter was reviewed at the clinical and reception team meeting where staff were reminded of the protocol for the alarm and were advised to check as to whether it was a false alarm at all times. Significant events were discussed in practice and clinical meetings and those that led to actions were reviewed. All events were discussed to assist in staff training and development.

National Patient Safety Alerts were disseminated by the practice manager to all staff. Staff were able to give examples of recent alerts that were relevant to their patients or their area of responsibility. For example, a recent alert regarding the potential outbreak of Ebola was discussed at the monthly practice meeting.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults.

We looked at records which showed that most staff had received child protection and safeguarding training. The practice had a dedicated lead for safeguarding vulnerable adults. Clinical staff had received Level 3 child protection training; this training was current and in date. Administration staff had received Level 1 child protection training. All staff that had completed child protection training had also completed training in safeguarding vulnerable adults.

Staff we spoke with were able to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and who to report concerns to.

Vulnerable patients and children included on the child protection register were highlighted in the electronic patient records so that staff were aware of concerns. The practice used the required codes on the electronic case management system to ensure staff could identify those patients who may be at risk. Those patients flagged up were placed on the practice's vulnerable patient's register. We saw evidence that the register was regularly reviewed at clinical meetings.

The practice had a chaperone policy which was visible in the waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and healthcare professional during a medical examination or procedure). All staff had been trained to undertake these duties. However the practice tried to use the practice nurse, if possible. All staff undertaking chaperone duties had received a Disclosure and Barring Service (DBS) check.

### Medicines management

One of the practice nurses was lead for medicines management. We checked the medicines stored in the medicines refrigerators and found they were all in date and stored securely. A daily record was maintained of refrigerator temperatures and all were found to be in the appropriate range to keep medicines safe.

The practice had a medicines management policy for staff to follow which included checking medicines expiry dates

## Are services safe?

on a monthly basis. We saw evidence of completed log sheets which confirmed these checks had taken place and were up to date. Any expired medicines were sent back to the pharmacy for disposal.

Vaccines were administered by the practice nurses in line with legal requirements and national guidance. We saw evidence that the practice nurses had received the appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance. The protocol outlined how staff were to process requests for repeat prescriptions and how to manage any request for a change to a prescription. The protocol also identified the frequency of when a medication on a prescription was to be reviewed and the appointed member of staff to carry out the review. We saw that a prescription for anti-hypertensive drugs was to be reviewed annually, anti-depressants were to be reviewed every two months and dementia drugs were to be reviewed six monthly. This ensured that patients' prescriptions were appropriate and under constant review. Prescriptions were reviewed and signed by the GP before being issued to the patient. An online repeat prescription service was available to patients.

### Cleanliness and infection control

We observed that most of the premises was clean and tidy, although we did find areas of dust on the shelves in the clinical rooms and on the top of the curtain rails. We also found dirt under the treatment couches in three of the treatment rooms.

The practice employed a cleaning company and we were told that there were concerns over the cleaning service provided. Staff told us that the concerns had been raised with the cleaning company, but no evidence was provided. We were informed that the premises had recently undergone a deep clean, but were not provided with evidence of this. A book was used to communicate daily messages to the cleaners. There was no evidence of cleaning schedules or cleanliness audit carried out by the practice.

An infection control policy was in place and was available for staff to refer to. This enabled them to plan and implement infection control measures. For example, it explained how to manage urine spillage and how to dispose of clinical waste. All staff had received infection prevention and control training. We were provided with

evidence of where update training was provided within practice meetings. The practice had a named infection control lead. Antiseptic gel was available throughout the practice and signs were visible encouraging patients to use the gel to minimise infection risk.

We were provided with evidence of legionella testing carried out in 2013 and regular testing of water temperatures.

### Equipment

We checked the practice equipment maintenance records and found that all equipment had been checked and calibrated in October 2014. This included PAT testing and the calibration of thermometers and medicine fridges.

Staff we spoke with told us that they had enough equipment, including personal protective equipment, such as gloves and masks, to enable them to carry out diagnostic treatments and to maintain administrative records.

### Staffing and recruitment

The practice had a recruitment policy and procedure, which covered the submission of an application form, pre-employment checks, references and interview process. We looked at ten staff files and found that references were missing for some members of staff. However since the inspection, the practice has provided appropriate evidence of references for staff. Disclosure and Barring Service (DBS) checks had been carried out for all members of staff.

We were informed about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patient's needs. If the GP's were undertaking teaching duties, a regular locum would be deployed to cover sessions. In the long term salaried GP's were being employed to cover regular teaching duties of existing GP's.

Staff told us there were usually enough staff to maintain the smooth running of the practice and enough on duty to ensure patients were kept safe.

### Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. This included health and safety risk assessments and policy, medicines management protocols and procedures to deal with an emergency.

Risks identified were discussed in practice meetings and an action plan identified. A recent discussion focussed on staff

## Are services safe?

failure to respond when a panic alarm button was used by a member of staff in need of assistance when a patient collapsed in a consultation room. This resulted in a failure for help to arrive promptly. Further training was given to staff to ensure the correct use of the panic button as outlined in the practice policy.

We saw that staff were able to identify and respond to changing risks to patients. For example, we saw an acutely ill child who had been brought to the practice by their parent was seen as an emergency appointment by the duty GP. Staff also gave examples of how they responded to patients experiencing a deterioration of their mental health. This included providing a referral to the local mental health team for review.

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

The practice had arrangements in place to manage emergencies. Staff we spoke with had received basic life

support training. Emergency equipment and medicines were available, including oxygen and defibrillator. All staff knew the location of the equipment which was accessible to all staff if required. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All emergency medicines we checked were in date.

The practice had a business continuity plan to ensure it was able to continue to provide a service to patients. This included the transfer of appointments to the practice's other site at Ching Way. In the event of forced relocation, patients would be telephoned to explain the circumstances and an explanatory recorded message would be left on the practice's answer machine.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GP's and nursing staff we spoke with were familiar with current best practice guidance. This included guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Best practice was discussed in clinical meetings. We were provided with copies of meeting minutes where new guidelines were discussed and the implications on practice performance and patient care considered. They GP's told us that they lead in specialist clinical areas such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD) and that they were supported in this work by the practice nurse.

Staff told us, and evidence confirmed that any changes in practice were to ensure that patients were given the best support to achieve an effective health outcome. Each patient received an assessment and diagnosis in line with the most current guidelines. The needs of patients were discussed at clinical meetings and individual patient cases were reviewed to provide an up to date assessment when appropriate.

The practice used a risk stratification tool to identify patients who may be at a higher risk and who might require a more detailed needs assessment. This group included those patients with a higher than average attendance at accident and emergency and those on the practice at risk registers. These patients were called into the practice for a consultation with the GP to discuss their health conditions and a plan was put in place to avoid further attendance at accident and emergency. Each patient received a care plan which was regularly reviewed.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GP's we spoke with used national standards for the referral of patients with a suspected cancer who were referred and seen within two weeks. We saw minutes of clinical meetings where referrals were reviewed.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GP's, practice

nurse and the practice manager showed that the culture in the practice was that patients were referred on needs, and that no other factors, such as age, sex or race were taken into account in the decision making process.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information collected was used to support the practice to monitor and improve patient outcomes.

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local Clinical Commissioning Group (CCG) as a whole against the national average. The latest available published QOF data showed that overall the practice is performing above the CCG average (93.4%) and the national average (93.5%) achieving 98.2%. This was a general figure which included all areas that QOF covered (clinical care, how well the practice was organised, patient views, amount of extra services offered by the practice).

The practice's performance had been reviewed through clinical audits. Audits included a review of prescribing of Phosphodiesterase 5 inhibitors (a drug to aid erectile dysfunction) in line with NHS guidance. The audit showed that out of 142 patients that received the medication, 24 patients were issued more than 4 tablets per month. The practice followed up these patients by writing to them to explain the guidelines and reducing their prescription to 4 per month. We were also informed of an audit that was being undertaken relating to patients who were diagnosed with asthma. However, we were not shown evidence of this. The practice was able to demonstrate completed audit cycles where changes had been implemented and their impact reviewed. For example an audit into the admission to secondary care for patients over 75 for falls showed a reduction between 2012 and 2013 through more proactive care at the practice. The clinical team was making use of CCG benchmarking process, being compared with other local practices. This included reviewing patient attendance at accident and emergency and offering a follow up consultation at the practice. We

# Are services effective?

## (for example, treatment is effective)

viewed notes of clinical meetings where practice performance compared to other local practices was discussed in line with the CCG average and ways to improve performance considered.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register, which currently had 44 patients on, and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice had a named member of staff to co-ordinate palliative care within the practice. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

### Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. The practice did not maintain a staff training log. We looked at individual staff files and saw that staff were up to date with mandatory training such as basic life support, however some staff were in need of reviewing safeguarding and child protection training. All GP's were up to date with their yearly continuing professional development requirements and all were currently undergoing the revalidation process. (Every GP is appraised annually and undertakes a fuller assessment called "revalidation" every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

The practice is a training practice. Many GP's undertook further training activities and managerial responsibilities, both within the practice and in the wider area of the Clinical Commissioning Group (CCG). This caused them to reduce their clinical sessions. In order to continue service to patients, the practice employed salaried GP's as cover on a regular basis.

All staff undertook annual appraisals that identified learning needs and from which action plans were documented. We were told by the practice manager that the practice was proactive in providing training but there was no evidence of a training log to confirm this.

From our review of staff files we saw that when poor performance had been identified, appropriate action had been taken and support given to manage the situation.

### Working with colleagues and other services

The practice engaged with other health services to ensure a multi-disciplinary approach to the care and treatment of those patients with complex care issues.

We were informed that the practice had a good working relationship with the palliative care team, Macmillan Nurses, community midwives and local mental health teams. However, due to the staffing shortages of many of the teams, joint meetings had become less frequent than the previously monthly meetings. The meetings discussed the needs of complex patients, for example those with end of life care needs and children on the at risk register. Any decisions about joint care planning were documented in a shared care record. The practice recognised the need for regular meetings with other professionals and were addressing the issues with these happening.

Blood tests, x-ray results, hospital letters and information exchanged with the out of hours provider were managed electronically and reviewed by administration staff and passed to the relevant GP to take appropriate action the same day.

### Information sharing

The practice used the electronic choose and book system for making referrals. In the previous year the system was used for 63% of referrals made. The system enabled patients to choose which hospital they wished to be treated in and book their own outpatients appointments in discussion with their chosen hospital.

The practice had systems in place to provide staff with the information that they needed. This included an electronic patient record card which was used by all staff to coordinate and document treatment. The software enabled all paper communications such as hospital letters to be scanned onto the electronic record. We did not see any evidence of these systems being audited.

### Consent to care and treatment

We found that clinical staff had an understanding of the requirements of the Mental Capacity Act 2005 and the Children's and Families Act 2014. This knowledge had been passed on to non-clinical staff at practice meetings. We viewed minutes that confirmed this. Staff were aware of the key parts of the legislation and were able to demonstrate its relevance and importance to the service. For example, staff spoke of the need to ensure appropriate consent to treatment was obtained from patients who may have a

# Are services effective?

(for example, treatment is effective)

learning disability and be unable to give informed consent. We found that 35 of the 40 patients on the learning disabilities register had an agreed care plan with the practice preparing plans for the remainder.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have legal capacity to consent to medical examination and treatment). We were shown the practice consent policy which addressed these areas and set out the procedure for the practice staff to follow. The practice also had a patient agreement to investigation or treatment form which was produced in order to gain consent for specific treatments such as surgical procedures. Once signed, the forms were scanned into patient records.

## Health promotion and prevention

All new patients were requested to complete a new patient questionnaire and were offered a health check to discuss lifestyle and ways that it could be improved. This included height, weight and blood pressure checks, as well as healthy eating and smoking cessation advice. Following registration the health check was offered to all patients on an annual basis. The practice had undertaken cervical screening for 80% of patients that qualified. This is an area that the practice were looking to improve through health promotion. Chlamydia testing and sexual health advice was also offered as part of the initial consultation for those patients within the age range for testing. The practice also offered a full child immunisation programme.

Immunisation rates at the practice were high, compared with the CCG average. For example, the practice had vaccinated 82.4% of children aged 24 months using the MMR vaccination, while the CCG average was 78.9%.

The practice offered annual health checks for older people and those placed on the long term conditions register. This included diabetes checks and blood pressure monitoring, as well as a physical health check. The practice also undertook chronic obstructive pulmonary disease (COPD)

checks and regular health checks, including physical checks for those on the long term conditions register. The practice undertook cognitive testing and had diagnosed 110 patients with dementia in the last 12 months. The practice offers follow up consultations to older patients and those with long term conditions when they are discharged from hospital. Those patients and their carers were given the appropriate support from the practice and were signposted to the relevant agencies, including the local Carers Association, which provides further support.

All patients over the age of 75 were allocated a named GP and could book an appointment in advance to see their named GP. However if they needed an emergency appointment they would be given an appointment with the duty doctor or any GP that was available at the time.

The practice held a register of patients whose circumstances made them vulnerable. Those patients with a learning disability were offered longer appointments to give time to discuss health concerns. We looked at patient records and found that all the patients on the register received an annual follow up appointment and physical health check. Those who attended the practice who were homeless would be seen as a temporary patient, but would be referred to the local poly clinic which provided a medical service specifically to the homeless.

The practice maintained a register of patients experiencing poor mental health. Each patient received a care plan and an annual review. We saw that 71% of patients on the register had received a review so far this year. The review included a physical health check. We reviewed care plans for patients on the mental health register and on the long term conditions registers and found them to be up to date and relevant to the patients' conditions. The practice worked with a consultant psychiatrist to undertake mental health assessments and GP's attend mental health reviews.

Health advice leaflets were available. However, leaflets were only available in English.



# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice relating to patient satisfaction. This included information from the National Patient Survey and the annual patient survey undertaken by the practice's Patient Participation Group (PPG). The evidence from these sources showed that patients were happy with the service they received. Patients felt they were listened to by staff and treated with respect. Data from the National Patient Survey showed that 86% of patients said that the GP's were good at listening to them. This was above the Clinical Commissioning Group (CCG) average. In addition, 88% of patients said that the overall service was good. This was also above the CCG average of 76%.

Patients completed CQC comment cards prior to the inspection to provide us with feedback on the practice. We received 37 completed cards. The majority of comments were positive about the service provided. Patients said that the premises were clean and tidy and that the staff were friendly and helpful. Patients did not feel rushed in appointments and always felt involved in decisions. Some comments were less positive, stating that there was a long wait to get an appointment, especially if they wished to see a specific GP, and there were long waiting times when attending for an appointment. We spoke with ten patients on the day of the inspection. Some patients we spoke to were positive about the service while others shared the concerns regarding waiting times.

Staff told us that all consultations were carried out in the privacy of the consultation room. Curtains were provided in consulting rooms so that patient dignity was maintained during examinations. We saw that the consulting room doors were closed during a consultation to maintain confidentiality. The practice provided a chaperone if a patient requested. Information was on display in the waiting area to alert patients to the chaperone service.

We noted that patients were asked to queue behind a rope barrier some distance from the reception desk, allowing the patient at the head of the queue to speak with the receptionist confidentially. If a patient wanted to talk in private, a side room was available to facilitate this.

Staff told us that if they had any concerns or observed any discriminatory behaviour they would raise these with the

practice manager to investigate. Once investigated, any incidents would then be discussed in practice meetings to provide training. We were provided with a copy of the minutes of the practice "away day", when staff had discussed scenarios that had taken place and staff were asked to provide the resolution. An example was of a patient being abusive and demanding that their referral to be done urgently. Staff identified ways to relieve the situation and ways to record the incident.

We found that the practice had a culture of ensuring patients were treated equally. This was backed up with a practice equality policy. Therefore patients with mental health concerns or in a vulnerable condition were able to access the service without fear of prejudice, and staff treated them equally.

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

Patient survey information that we viewed showed that patients were positive about their involvement in the planning of their care. The National Patient Survey showed that 73% of patients said that the GP's were good at involving them in the decisions about their care. This was above the CCG average. Eighty per cent of patients said the GP was good at explaining test results and treatments. This was also above the CCG average. However, only 58% of patients said that the nurses were good at involving them in their care decisions, which was below the CCG average.

Patients we spoke with on the day had no concerns over their involvement in their treatment. Patients said that they felt fully involved in the decision making process and that all treatment options were made known to them.

Staff told us that a bookable translation service was available to patients who did not have English as their first language. Staff told us the practice had attempted to offer translations of its own health leaflets but had had difficulty over the accuracy of the translation.

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

Patients told us they were confident that they received emotional support from the practice when it was needed. Staff informed us that if they were aware of an issue that required more time, for example when a GP could provide emotional support in the event of bereavement, a double appointment would be made to discuss all the issues. If patients required additional support, the practice would

## Are services caring?

refer to a local counselling service. The practice would send a condolence card and members of the practice staff would attend the funeral to provide further support if it was deemed appropriate.

The practice had a carer's policy and the practice computer system alerted GP's if a patient was also a carer. We were shown a copy of the information given to carers that signposted them to local support groups.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found that the practice was responsive to patient needs and had a system in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to ensure that the practice remained current to the local population needs. The practice had a large working age population and provided extended hours appointments to ensure that those patients could attend at a convenient time. The practice also used the choose and book system for referrals, ensuring that working people could receive a referral appointment at a location and time that was convenient to them. The practice used a risk stratification tool provided by the Clinical Commissioning Group (CCG). This was used to identify patients that were more at risk, to plan services and prevent unwanted patient outcomes. For example, inappropriate attendance at accident and emergency. The tool allocated a risk score to patients dependent on the complexity of their health concerns, with more resources being allocated by the practice to those at the higher end of the risk spectrum.

Longer appointments were available for patients who requested them and those with long term conditions. There was a system where elderly patients and those who were vulnerable were able to access an appointment with their named GP. However there was often a long wait for an appointment with a specific GP and many would have to take an earlier appointment with another GP or the duty GP. The practice provided a service to the residents of two care homes. Meetings took place with staff at the care homes to discuss individual patient care needs. We spoke with staff at the homes who were happy with the service provided to their residents.

Home visits were available for those patients unable to come to the practice. The practice also offered telephone consultations on a daily basis.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss patients' and their families' care and support needs.

The practice Patient Participation Group (PPG) met on a monthly basis, discussing the needs of the patient population and raising specific issues with the practice. We saw copies of the minutes of a meeting when the

introduction of a practice newsletter was discussed. The newsletter had since been introduced by the practice. It provided helpful information to patients, including health advice and information on special events taking place at the practice, for example the annual Macmillan coffee morning. We spoke with the chair of the PPG and were informed that the practice worked well with the group and that all suggestions for service improvement were considered.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. For example, those patients with "no fixed abode", a temporary registration with the practice was offered, with the practice's address being used for any letters regarding on-going treatment. Patients were then referred on to local community health services.

The practice had access to a telephone translation system which could be booked for consultations. The practice did not provide written literature in languages other than English. The practice had looked into the provision of this service, but found that there were too many inaccuracies and were looking at further ways to provide this.

The premises were suitable for use by people with reduced mobility with consultation rooms on both floors. If needed, the GP would work from a ground floor consultation room to allow patients better access. A lift to the second floor of the practice was available for patients that could not manage the stairs.

The practice actively supported people who had been on long term sick leave to return to work by the use of the 'fit note' and a phased return to work.

### Access to the service

Appointments were available between 8am and 6.30pm on Tuesday to Friday. The practice operated extended hours on Mondays between 6.30pm and 8pm for appointments for patients of working age. The GP's provided telephone consultations at the end of each clinical session and home visits were available for patients unable to attend the practice.

Concerns had been raised by patients regarding the availability of appointments and the long wait to see a GP. On the day of inspection we checked the booking system and found that the first pre-bookable appointment for one of the GPs was 28 November 2014 (a wait of 3 weeks), and for another the first available appointment was 2

# Are services responsive to people's needs?

(for example, to feedback?)

December 2014 (a wait of 4 weeks). The practice had responded to the waiting times by providing a duty doctor to deal with urgent appointments. The practice had also increased the use of nurse practitioners for the same reason.

Information was available to patients on the practice website and in the patient leaflet. This included how to arrange routine and urgent appointments through the practice appointment system. There was also information regarding the arrangements in place to ensure patients received medical assistance when the practice was closed, by contacting the out of hour's provider. If patients called the practice when it was closed, the practice answer machine directed them to the out of hour's provider. The practice had an online booking system which patients could access via the practice website. The practice used a text message reminder system to those patients who had provided their mobile telephone number. This provided appointment reminders and confirmation of any online bookings made.

## **Listening and learning from concerns and complaints**

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

We saw that information regarding the complaints procedure was available to help patients understand how to make a complaint and was displayed in the reception area. However, at the time of inspection, the information is concealed by another notice. Patients we spoke with were aware of the procedure, but told us they had never needed to make use of it.

We looked at two complaints received in the last 12 months and found they had been responded to appropriately, in line with the practice procedure. Complaints were reviewed by the practice annually to identify any trends and, if so, how the trends should be addressed. One of the main trends was the lack of appointment availability and the practice responded by introducing the duty doctor system.

We saw evidence from minutes of practice meetings which showed when complaints and any lessons learned from them had been discussed.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The lead GP and the practice manager met on a weekly basis to discuss the immediate needs of the practice and any plans for the future. The practice looked at developments in the NHS and which services the practice might be able to provide in future when developing the following year's business strategy. This included the proposals to develop an anti-coagulation service, which would incorporate further staff training. The current plan focussed on what was open to the practice financially and providing a service to benefit the practice's patient population.

### Governance arrangements

The practice had a number of policies and procedures in place to govern service provision. These were available to staff both on the computer system and within the staff policies folder. We reviewed five policies and found them to be relevant to the operation of the practice. All policies had been regularly reviewed and included a note of when the last update had been made and the next review due. Named staff members were given responsibility to specific areas of governance within the practice which included medicines management, infection prevention and control, safeguarding and long term conditions management.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. This data showed that the practice was currently performing above national average. QOF data was discussed at practice meetings, as were ways to improve those areas where the practice was performing at a lower standard. At a recent meeting, ways to increase prescribing rates and efficiency were discussed, including consideration of batch-prescribing.

The practice had arrangements in place to ensure that risks and significant events that occurred were documented and discussed at meetings to ensure learning from the events. However the practice did not have a risk register to catalogue known and potential risk to the practice in order to develop an action plan to reduce risk.

Good practice was discussed during practice away days. At a recent away day staff discussed employment issues, the development of a protocol for the duty receptionist position, together with training opportunities, such as further cancer training.

### Leadership, openness and transparency

The practice had a clear leadership structure, with named members of staff in lead roles. For example, there was a GP lead for safeguarding and the practice nurse was lead for infection control. Each of the GP's also had specific clinical areas of responsibility, such as paediatrics, diabetes, gynaecology and mental health, based on the GPs' special interest. We spoke with staff who were clear about their role and responsibilities. They said that they felt valued and supported by the management. They knew that they could go to a member of the management team for advice and support, if it was required. However, some members of staff raised concerns regarding a forced change in their job role. This had been caused by external policy decisions, which the practice was seeking to address. Staff told us that there was an open culture and all felt happy to raise concerns in practice meetings. A slot was reserved on every agenda for staff to raise concerns.

The practice manager was responsible for human resources policies and procedures. We were shown a number of related policies which were in place to support staff, including the induction policy, staff training policy and absence policy. Staff we spoke with knew where to find the policies on the computer system and in the staff handbook folder, if required.

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

The practice had gathered feedback from patients through the annual patient survey. We looked at the results and noted patients raised concerns over the waiting time in the surgery and the waiting time for appointments. The practice responded to this by introducing catch up time for GP's within the session. The practice had also responded by offering telephone consultations and a text reminder service to reduce the number of missed appointments.

The practice had an active Patient Participation Group (PPG) consisting of 264 members. However not all members attend the monthly meetings. The PPG organised the annual patient survey, arranged fund raising events such as the annual Macmillan coffee morning and set up health promotion events through the community library based at the library building. The PPG also raised patient concerns directly with the practice staff. This included the

# Are services well-led?

Good 

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

lack of parking spaces at the surgery and privacy issues at the front desk. This latter issue resulted in the installation of the rope barrier to keep the queue of patients at a distance from the front desk.

The practice gathered feedback from staff through staff meetings and annual appraisal discussions. Staff told us they were comfortable in giving feedback to the practice manager and GPs and were happy to discuss issues with colleagues and management. Staff told us that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff on the shared computer system and in the policy folder located in the administration office. Staff we spoke with were aware of the policy and where it was held, but had not had needed to use the policy.

## Management lead through learning and improvement

Staff told us that the practice supported continuing learning and development through training and mentoring. We looked at staff files and found that regular appraisals took place, which included a personal development plan. The staff files also verified that training had been provided, although the practice did not maintain a consolidated central training record.

The practice had completed reviews of significant events and other incidents and shared the outcomes with staff during practice meetings to ensure the practice improved outcomes for patients. For example, when prescription pads were stolen from a consulting room, the security arrangements were discussed to ensure all staff were aware of the correct procedures for storing prescription pads and for keeping the premises secure.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control  <b>People who use services were not protected against the risks associated with poor infection control because the practice did not:</b>  1. Carry out an infection prevention and control audit;  2. Did not have cleaning schedules in place to monitor the cleaning of the premises.
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	