Dr Ayoola Makanjuola

Quality Report

Bicknoller Surgery
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Date of inspection visit: 23 October 2014
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of the Dr Makanjuola practice on 23 October 2014. We rated the practice as 'Good' for the service being caring and responsive to people's needs. We rated the practice as 'Requires improvement' for the service being effective. We rated the practice as 'Inadequate' for the service being safe and well led. We rated the practice as 'Requires improvement' for the care provided to older people, families, children and young people, working age (including those recently retired and students), people experiencing poor mental health (including people with dementia), people with long term conditions and people whose circumstances may make them vulnerable.

We gave the practice an overall rating of 'inadequate'.

Our key findings were as follows:

- There was good access to the surgery through the open access in nature of the appointment system;
- Patients were positive about the practice and services provided. They were happy with the opening times and appointment flexibility.
- Patients said that staff were welcoming, caring and treated them with dignity and respect.
- Systems were in place to keep patients safe including incident reporting protocols and safeguarding procedures;
- Annual reviews were offered to all older patients and those on the long term conditions registers.

There were also areas of practice where the provider must make improvements. The practice must:

- Ensure all chaperones have a Disclosure and Barring Service (DBS) check;
- Ensure all recruitment checks are carried out before employment commences;
- Ensure fridge temperatures and recording systems are in line with national guidelines;
- Ensure current guidelines are being used for the diagnosis of all conditions and in particular for the treatment of COPD;
- Ensure equipment is kept in date including urinalysis testing strips and blood bottles.
- Ensure audit cycles are undertaken;
- Ensure the appropriate storage and logging of prescription pads.

Summary of findings

There were also areas where the practice should make improvements. The practice should:

- Ensure there is provision for patients when the practice nurse is absent;
- Ensure all significant events are recorded, action taken and then discussed with staff to ensure learning from the event;
- Ensure there is a record of all meetings that take place in the practice;
- Produce own cleaning schedules and cleaning log;
- Produce a practice risk register, fire risk assessments and fire log;
- Ensure the practice regularly benchmarks services against the local Clinical Commissioning Group (CCG) data;
- Review patients that are discharged from hospital to their own home;
- Produce a long term practice strategy document;
- Ensure legionella risk assessments and testing is undertaken

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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?

Inadequate

The practice is rated as inadequate for providing safe services as there are areas where it must make improvements. Not all significant events were being recorded and staff showed little awareness of the significant event reporting process. When things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated to support improvement. Although risks to patients who used the service were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. This included inadequate fridge temperature gauges and poor temperature record keeping, no Disclosure and Barring Service (DBS) checks for chaperones, lack of infection control training, missing adrenaline from the emergency medicines bag and a failure to carry out full pre-employment checks including references.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or below average for the locality. Knowledge of and reference to national guidelines was inconsistent. There were no completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population however there was no evidence of the practice engaging with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

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

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy and staff were unclear over the plans for the future development of the practice and there were no plans to achieve the vision and strategy. We found up to date policies and procedures with responsible persons assigned to areas of clinical governance. We found that there was a lack of clarity about authority to make decisions and there was confusion between staff over responsibility for some areas of clinical governance For example infection prevention and control and long term condition management. The practice proactively sought feedback from staff and patients. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

What people who use the service say

During our inspection we spoke with nine patients at the surgery and collected 40 comment cards that had been completed by patients prior to the inspection visit.

Patients were happy with the service provided and said that they felt listened to and cared for by staff. They felt involved in their treatment decisions. Patients said that they liked the system of appointments where they could just turn up and have a guarantee that they would be seen by the GP that day even if they had to wait.

We viewed the national GP patient survey for 2014 and found that 84% of the patients that completed the survey found it easy to get through to the surgery by telephone, which is higher than the local Clinical Commissioning Group (CCG) average of 63%. However 75% of patients said that the GP was good at listening to them, which was lower than the CCG average of 87%.

The practice carried out its own patient survey in March 2014 and found that 66% of patients found the appointment system convenient and 76% said that the GP treated them with care and concern.

The main concern that was raised by patients was that receptionists were not able to adequately help with enquiries when the patients telephoned the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure all chaperones have a Disclosure and Barring Service (DBS) check;
- Ensure all recruitment checks are carried out before employment commences;
- Ensure fridge temperatures and recording systems are in line with national guidelines;
- Ensure current guidelines are being used for the diagnosis of all conditions and in particular for the treatment of COPD;
- Ensure equipment is kept in date including urinalysis testing strips and blood bottles.
- Ensure audit cycles are undertaken;
- Ensure the appropriate storage and logging of prescription pads.

Action the service SHOULD take to improve

- Ensure there is provision for patients when the practice nurse is absent;
- Ensure all significant events are recorded, action taken and then discussed with staff to ensure learning from the event;
- Ensure there is a record of all meetings that take place in the practice;
- Produce own cleaning schedules and cleaning log;
- Produce a practice risk register, fire risk assessments and fire log;
- Ensure the practice regularly benchmarks services against the local Clinical Commissioning Group (CCG) data;
- Review patients that are discharged from hospital to their own home;
- Produce a long term practice strategy document;
- Ensure legionella risk assessments and testing is undertaken.

Dr Ayoola Makanjuola

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, practice manager and practice nurse. Each member of the team was granted the same authority to enter the practice as the CQC lead Inspector.

Background to Dr Ayoola Makanjuola

The Dr Makanjuola practice is a surgery located in the London borough of Barnet. The practice is part of the Barnet Clinical Commissioning Group (CCG) which is made up of 69 practices. It currently holds a PMS contract and provides NHS services to 2000 patients. The practice serves a diverse population group where many patients do not have English as their first language The practice does not have a large older population (14% of the patient list) with 41% between the ages of 18 and 65. The practice runs an open access clinic each day between 9am and 11am and between 5pm and 6.15pm. The practice closed on a Thursday afternoon and patients were directed to the out of hour's service provider. Pre bookable appointments are between 4.30pm and 5pm each afternoon except Thursday. Appointments for the practice nurse are available on a Monday and Wednesday. The practice runs an extended hour's clinic on a Monday between 6.30pm and 7.30pm. The GP provides telephone consultations and home visits each day for those unable to attend the practice. The practice staff comprised of 1male GP, a part time nurse, practice manager and reception staff. The practice employs a full time chaperone who helps in reception when needed. The practice has opted out of out of hours provision and refers patients to the '111'service.

The practice is situated within a purpose built health centre and shares facilities with three further health providers. Consulting rooms are on the ground floor with wide doors to allow wheelchair access.

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. However the practice does not currently undertake any surgical procedures.

The practice provides a range of services including child immunisation, smoking cessation advice and clinics for those with long term conditions.

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 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 has not been inspected before and that is why we included them.

Detailed findings

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 such as Healthwatch, NHS England and Barnet Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 23 October 2014. During our visit we spoke with a range of staff (GP, Practice Nurse and administrative staff) and spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used information from a range of sources to identify risks and improve quality in relation to patient safety. For example national patient safety alerts and significant events recording. The practice also reviewed complaints received from patients. For example, a recent recorded significant event involved a ceiling tile falling close to a patient waiting at the reception desk. This was reviewed by the practice and referred on to the centre's maintenance service that repaired the ceiling to make it safe.

We reviewed safety records and incident reports which showed that events that had been recorded had been managed appropriately. For example we were informed of an incident where a patient came to the surgery to request a prescription. The GP prescribed alternative medicines to that requested but the patient was not happy and became aggressive causing the practice to call the Police. This incident had been recorded and discussed at the practice meeting. However we found that not all significant events that we were informed of had been recorded.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events however they were not always following it. We found that there was some evidence of significant event recording and near misses. However some incidents that were made known to us were missing from the reporting system, such as an incident of the surgery flooding where the medical centre was forced to close. We found evidence where incidents were discussed by the GP and practice manager which showed some learning from the incidents that had been reported. However reception staff showed little awareness of the significant event reporting process.

Incident forms were available for staff to complete. Once completed, the practice manager used a system to manage and monitor the incident ensuring that responses were comprehensive and given in a timely manner. Evidence of action taken was shown to us. For example we were shown the record of an incident where a patient was abusive towards reception staff when requesting medication. The report shows where the GP gave emergency medication on the day of the incident, details of the review meeting and the action to issue a letter to the patient explaining that there was a zero tolerance policy towards any abuse of staff within the practice. We viewed a zero tolerance notice in the reception area.

National patient safety alerts were received by the GP and practice manager and disseminated to practice staff. We were shown evidence of meeting minutes where these were discussed in to ensure all staff were aware of any that were relevant to the practice and where action was to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a child protection protocol reviewed in November 2013 and a vulnerable adults policy reviewed in December 2013. Although the child protection protocol had been reviewed, there were no contact details attached to the protocol. There was however a list of contacts in the practice manager's office which were accessible to staff. We asked members of clinical and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documenting of safeguarding concerns and who they should contact both internally and externally with their concerns.

The GP was the designated safeguarding vulnerable adults and children lead. All staff were aware who the safeguarding lead was and who to speak to if they had a safeguarding concern within the practice. All clinical staff had received safeguarding training and level 3 child protection training. Non clinical staff had received Level 1 child protection training.

There was a system to highlight vulnerable patients by issuing codes on the practice's electronic records. This alerted staff to relevant issues when patients attended appointments. This included children subject to child protection plans, a child in need, looked after children and older people who may be vulnerable through living alone. The GP attended child protection case conferences and reviews where appropriate. The GP provided a written report for the conference if unable to attend.

A chaperone policy was in place and offered to all patients upon booking an appointment. A notice was on display on

the reception desk. Chaperone duties were undertaken by an employed chaperone who also undertook some front line reception duties. If the chaperone was unavailable, the practice manager would act as the chaperone. Both the chaperone and the practice manager received full training in chaperone duties. However the chaperone and practice manager had not received a Disclosure and Barring Service (DBS) check.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on the electronic system which collated all communications about patients including scanned copies of communications from hospitals. We were told by staff that an audit of these records had not been carried out to ensure the accuracy and completeness of the information held.

Medicines management

We checked medicines stored in the treatment rooms and medicine fridges. We found three fridges in which vaccines were stored. Fridges did not have adequate thermometers and the fridge in the nurse's consultation room did not have a numbered thermometer. The gauge only showed whether the temperature was safe or unsafe. Temperatures were monitored and logged by the receptionist on a daily basis however there were gaps in the recording of the daily temperatures. The temperature monitoring logs showed several entries of zero or above eight degrees (vaccines should be stored at a temperature between two and eight degrees Celsius). Staff were unaware of the need for temperatures to be kept between two and eight degrees and told us they thought the recorded temperatures were acceptable. We found no process for staff to take action if vaccines were found to be stored at an incorrect temperature and no significant event report. These concerns were raised with the GP at the inspection regarding the monitoring of fridge temperatures and possible harm to vaccines through unsafe storage. The GP was advised to not undertake any vaccinations until advice had been sought. The Public Health England (PHE) guidance on the safe storage of medicines was left with the practice for guidance. After the inspection we were informed by the practice that the medicine fridges had been replaced within 5 days of the inspection visit and the practice's medicines supplier was contacted. The practice was advised to destroy all vaccines and new vaccines were issued.

Vaccines were administered by the GP but not all national guidelines were being adhered to as there was no adrenaline present in the emergency medicines kit.

Processes were in place to check medicines were within their expiry date and suitable for use. All medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice undertook annual medicines management review meetings with the local prescribing advisor to review practice medicines policy and best practice guidance. However we were not provided with copies of meeting minutes to confirm these meetings took place. We were provided with a protocol for the storage of non-controlled drugs and staff showed awareness of latest National Institute for Health and Care Excellence (NICE) guidance.

There was a policy for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all the required areas. For example how repeat prescriptions were monitored by the practice and how staff issue a repeat prescription. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by the GP before they were given to the patient. However the practice did not have a process for booking blank prescription pads in or out of the practice, and no log of who the prescription pad was issued to.

Cleanliness and infection control

We found the premises to be clean and tidy, however consultation rooms were cluttered. The practice did not hold cleaning schedules. We Were told it was the responsibility of the main health centre maintenance team to undertake cleaning.

The practice had a lead for infection control however there was confusion between staff as to who the lead was. All staff had received infection training specific to their role. We saw evidence that the practice carried out an annual infection control inspection. The latest inspection dated October 2014 showed no issues. However for some areas inspected it was noted that it was 'building maintenance responsibility'. There was no evidence that the practice had undertaken their own inspection of the areas to ensure that infection control was up to standard. For example there

was no evidence in the practice infection control inspection that the furniture in consulting rooms was in a good state and that work surfaces were clean and clear of clutter. The practice had no system in place to ensure that the areas the practice was not responsible for were being appropriately maintained.

An infection prevention and control policy was available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, hand washing procedures were described and personal protective equipment (PPE) was outlined. Staff were able to demonstrate how PPE would be used in line with national guidelines. The procedure for dealing with needle stick injuries was also covered in the policy.

We found no evidence that the practice carried out legionella (a germ found in the environment which can contaminate water systems in buildings) testing, risk assessment or investigation.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We were provided with certificates for equipment testing and calibration dated February 2014. This included the testing of the fridges, BP monitors and baby scales. There was no evidence of portable appliance testing (PAT).

The practice did not hold a schedule for checking the expiry date of equipment. We found two bottles of hand gel in the nurse's consultation room that had expired in 2003 and 2013. We also found that the urinalysis testing strips were also out of date, and blood bottles in both the GP and nurse's consulting rooms had expired and posed a significant safety issue. This was highlighted with the practice and they were removed from use.

Staffing and recruitment

Records we looked at did not contain all of the information that would be required to be gathered prior to employment. The staff records did not include proof of identification and pre-employment references. We were informed that verbal references were obtained but no record was kept on file. Disclosure and Barring Service (DBS) checks had not been carried out on staff members, including the designated chaperone. We were informed that the practice nurse was supplied by an agency that had completed a DBS check but no copy was kept on file. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We found that the practice was not following the written recruitment policy by ensuring staff had a DBS check and references were retained on file. There was no risk assessment present outlining the reasoning for not undertaking DBS checks.

We found that there was no arrangement for planning and monitoring the number of staff needed to meet patients' needs. The practice nurse was available for nine hours a week. We were informed that if a patient needed a dressing or planned nursing need when the nurse was not present, they were signposted to the local walk in centre. The GP provided cover for the nurse if absent. If the GP was away, a regularly used locum with some knowledge of the patients would be employed.

Monitoring safety and responding to risk

The practice had some systems in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual checks of the building, safeguarding and dealing with emergencies. We found no evidence of equipment maintenance schedules (however test certificates were available and up to date) and practice risk register. We were informed that cleaning schedules, fire risk assessments and practice fire log were the responsibility of the centre's management team and the practice did not undertake their own tests or hold their own records. The practice was unable to confirm that the management team had taken appropriate action.

The practice had a health and safety policy which was available for all staff to view in the practice manager's office. There was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and defibrillator (used to attempt to restart a person's heart in an emergency). We were provided with evidence to show that the equipment was maintained annually. All staff were aware of the location of the emergency equipment.

Emergency medicines were available in the GP consultation room and all staff knew of their location.

Inadequate

Are services safe?

Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use, however we noted that there was an absence of adrenaline for the use of treating anaphylaxis.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice, The plan included processes to follow if there was a loss of power or telephone system, external flooding and incapacity of employed staff.

The practice had not undertaken a fire risk assessment as they advised it was the responsibility of the centre management.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nurse we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For example the GP referred to current NICE based guidelines for long term condition management. However there was confusion over the management of long term conditions within the practice. The nurse reported that she did not diagnose chronic obstructive pulmonary disease (COPD). The nurse stated that she only sees patients for follow up appointments and monitoring. However the GP stated that he did not diagnose COPD as it was the responsibility of the practice nurse. There was a lack of communication between the GP and nurse which may have caused patients to not be diagnosed or not receive the most appropriate treatment. We found that the guidelines being used were not the most up to date.

Data showed that the practice was performing in line with CCG standards on referral rates for all conditions.

We found no evidence of discrimination when making care and treatment decisions. Interviews with staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in the decision making process.

Management, monitoring and improving outcomes for people

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 (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). The latest available QOF data showed that the practice was performing below the CCG average of 94.6% and below the national average of 94% achieving 91.2%. This was a general figure which included all areas of QOF covered (clinical care, how well the practice was organised, patient viewed, amount of extra services offered by the practice).

The practice used this information to gauge their performance and to identify areas where improvement was needed, however we did not see an action plan to identify areas where the practice could improve.

There was little evidence of any audit being carried out except QOF. There was a number of data gathering exercises carried out but no conclusions or action plans had been set for the data to be used for the improvement of service. For example data had been collected on the number of patients with asthma who are also smokers but no information was available as to how the data was to be used. We found no evidence of benchmarking against CCG data. There was no evidence of any prescribing audits that had been carried out. We found no evidence of any completed audit cycles.

Effective staffing

Practice staffing included medical, nursing and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory courses such as basic life support. The GP was up to date with their yearly continuing professional development requirements and was in the process of revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with the NHS England). The nurse had received no training in long term condition management but was involved in the provision of care and delivered annual patient reviews.

The nurse works for nine hours a week which meant that when not present the GP would take on the workload or patients would be advised to attend the local walk in centre instead of being seen at the practice.

All staff undertook annual appraisals which identified learning needs from which action plans were documented.

Working with colleagues and other services

We were informed that the practice had working relationships with the palliative care team and local mental health teams. The practice had undertaken three monthly meetings with the community nursing team but since the beginning of 2014 these meetings had ceased as the community nursing team stated that they did not have any spare staff to attend. We were provided with minutes of the

Requires improvement

Are services effective?

(for example, treatment is effective)

palliative care meetings held between the practice and the district nurse which reviewed the care plans for the patients on the practice palliative care list and also highlighted any further health concerns to be monitored.

The practice held meetings with staff of two care homes to discuss the needs of patients with long term conditions. The GP also attended meetings to discuss children on the practice at risk register. The GP liaised with the local mental health team who were contactable by fax or telephone if there was an emergency with a patient.

Blood tests, X ray results, hospital letters and information from out of hour's providers were received electronically by reception staff and reviewed by the GP who took appropriate action.

Information sharing

The practice used the electronic Choose and Book system for making referrals. The system enabled patients to choose which hospital they wished to be treated in and book their own outpatients appointment in discussion with their chosen hospital. The practice also used a shared system to share information with other health providers including the local hospital and out of hour's provider.

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 card. All staff had received full training in the system.

Consent to care and treatment

We found that clinical staff at the practice had received training in the Mental Capacity Act 2005 and the Children's and Families Act 2014. Administration staff had been made aware of this within practice meetings. Clinical staff that we spoke with were aware of the key parts of the legislation and were able to demonstrate how it was implemented in practice. For example, staff spoke of the need to ensure appropriate consent for treatment was obtained from a carer or the manager of the nursing home for patients with dementia.

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 provided with the practice policy for determining the capacity of patients under 16 to give consent and the procedure for the practice to follow.

Health promotion and prevention

All new patients were offered a consultation with the practice nurse to discuss their health circumstances and to receive information to help improve their lifestyle. This included healthy eating and exercise leaflets and smoking cessation advice. Chlamydia testing and advice was also offered as part of the initial patient consultation for those patients within the age range for this testing. The practice also offered a full adult and children's immunisation programme.

The practice held a register of patients who were identified as being at high risk of admission to hospital or at the end of life. Each patient had a care plan; we viewed five plans and found them to be up to date. These care plans were shared with other health providers and reviewed jointly by the practice nurse and district nurse. Each patient over the age of 75 received a named GP and access to a direct telephone line which bypassed the main appointments switchboard. The practice provided follow up consultations for those patients that had been discharged from hospital.

The practice offered structured annual reviews with their named GP to all patients placed on the long term conditions register which included diabetes checks and blood pressure monitoring. Some chronic obstructive pulmonary disease (COPD) checks were being carried out which included spirometry checks (measuring lung function) for those patients on the practice register. Summary care records were used to ensure that current patient concerns and medical histories could be presented to another care provider such as accident and emergency, to ensure continuity of care. Health advice was offered to all patients on the long term conditions registers and this was documented within the patient's notes.

A register was held of patients with a learning disability and each patient was offered an annual review which included a physical health check. We were not provided with information regarding the uptake of these reviews by the practice. All patients on the register were offered extended appointments to allow time to discuss health concerns.

The practice provided extended opening hours for patients who worked during normal opening times. An annual

Requires improvement

Are services effective?

(for example, treatment is effective)

physical health check, including weight and blood pressure monitoring was offered to working patients. The practice had a high uptake for cervical screening with 2% of patients who qualified left to attend for the test this year.

The practice shared the care of families, children and young people with the community midwives and health visitors however we were informed that multi-disciplinary meetings were not regular and we found no minutes of meetings. The practice operated a register of children at risk or in social service care. The GP attended meetings with social services to discuss the care of these patients. The practice provided all standard childhood immunisations and had a mixed performance. For example the practice had vaccinated 84.9% of 24 month old children with the MMR vaccination which was above the Clinical Commissioning Group (CCG) average of 80.3%, but they had only vaccinated 71.4% of babies for Meningitis C which was below the CCG average of 80.0%.

The practice worked with two care homes in the advanced care planning for patients with dementia and attended multidisciplinary care reviews to discuss individual cases. The practice informed us that they attended meetings with local mental health teams to discuss case management of patients on the practice mental health register. We spoke with staff at the care homes who confirmed that meetings do take place and that they were happy with the service provided by the practice. Patients were signposted by the practice to other organisations such as MIND for additional support.

Health advice leaflets were available within the reception area or direct from the nurse. However leaflets were only available in English. The practice accessed language line to help patients where English was not their first language.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and annual patient survey undertaken by the practice's Patient Participation Group (PPG). The evidence from these sources showed patients were happy with the service they received and they were listened to by staff and treated with respect. Data from the national patient survey showed that 84% of patients found it easy to get through to the surgery on the telephone which was above the Clinical Commissioning Group (CCG) average of 63%. The survey also showed that 85% of patients described their experience of making an appointment as good which was above the Clinical Commissioning Group (CCG) average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 40 completed cards and the majority were positive about the service experience. Patients said that staff were caring and that they felt listened to and involved in treatment decisions. However some comment cards were less positive and stated concerns regarding the receptionists being unhelpful when calling the practice.

We also spoke with five patients on the day of inspection who were happy with the service provided.

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 noted that the door to the consulting room was closed during a consultation to respect patient confidentiality. A chaperone was provided for all female patients if they wished to use the service. This service was highlighted on the reception desk.

The reception desk was situated a small distance from the seated waiting area which ensured that patients were not overheard at the desk. If patients requested to talk to receptionists in private, they were invited to talk at a side entrance to the reception area. Whilst on inspection we saw a patient who was hard of hearing who had difficulty communicating with reception staff and another patient had to intervene.

Staff told us that if they had any concerns or observed any discriminatory behaviour they would raise these with the practice manager who would investigate the circumstances.

We found that the practice had a culture of ensuring that patients were treated equally. Therefore those patients with mental health concerns or in vulnerable conditions were able to access the service without fear of prejudice.

Care planning and involvement in decisions about care and treatment

Patient survey information that we viewed showed patients responded positively to questions about their involvement in the planning of their care. For example, the national GP patient survey 2014 showed that 82% of patients said that the GP was good at involving them in their care, and 72% said that the GP was good at explaining test results and treatments which were both above the Clinical Commissioning Group (CCG) average.

Patients we spoke with said they were involved in their care and that all the options for treatment were explained to them. They also told us they felt listened to and supported by staff to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as their first language. Patients were asked by the receptionist if they required a translator. A translator would be pre-booked for an appointment. Information on the service was on display in the reception area.

Patient/carer support to cope emotionally with care and treatment

The survey information we viewed showed that people were positive about the emotional support that was provided by the practice. People told us that when they needed emotional support the GP would provide an appropriate referral to another service or by providing information of how they could access relevant support groups. We viewed information within the reception area for groups that offered external support.

The practice had a carer's policy and the practice computer system alerted GPs if a patient was also a carer. We were shown written information signposting carers to support groups. Patients who suffered bereavement were telephoned by the GP and invited to the practice to discuss how staff could be of any help.

Good

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 patients needs and had a system in place to maintain the level of service provided. The needs of the practice population was understood and services provided reflected this. The practice used a risk stratification tool provided by the Clinical Commissioning Group (CCG) to identify patients that were of higher risk in order to plan services.

The practice operated an open access clinic each day but pre bookable appointments were available for patients who requested them and for those with long term conditions.

The GP made home visits to two care homes each week to conduct a ward round. Home visits and telephone consultations were also available to those patients unable to attend the practice.

The Practice Patient Participation Group (PPG) met on a monthly basis and discussed the patient population and raised specific issues with the practice. At a recent meeting the development of messages on the electronic information display system was discussed. This is the electronic display which provides messages to patients in the waiting room. As well as informing patients that the GP was ready to see them, the PPG wanted to display further messages of services available at the surgery such as the flu clinic. Examples of recent suggestions taken on board by the practice include the introduction of a telephone message book for patients to leave non urgent messages for the GP and to request a call back.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. For example for those patients with "no fixed abode", temporary registration with the practice was offered and the practice address was used for any letters regarding treatment.

The practice had access to a telephone translation system which could be booked for consultations. The practice was unable to provide written literature in alternate languages to English.

The practice was situated on the ground floor of a health centre and access to the premises and consultation areas were fit for use by people with a physical disability.

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

Access to the service

The practice ran an open access clinic each day between 9am and 11am in the morning and each day except Thursday between 5pm and 6.15pm. Pre bookable appointments were between 4.30pm and 5pm each afternoon except Thursday. Appointments for the practice nurse were available on a Monday and Wednesday. The practice ran an extended hour's clinic on a Monday between 6.30pm and 7.30pm. The GP provided telephone consultations and home visits each day for those unable to attend the practice. The practice closed on a Thursday afternoon and patients were signposted to the out of hour's provider.

Information was available to patients in the practice leaflet and on the practice website, however it was difficult to locate the website and the site was in need of development. This information included the times of the sessions and how to book a pre booked appointment. The practice also provided the details of the local out of hour's provider and walk in centre at a local hospital. The practice did not offer online appointment bookings or online repeat prescriptions.

The practice's extended hours were particularly useful for those patients with work commitments. However some patients stated that it would be helpful for there to be more time allocated in this way.

Patients we spoke with were satisfied with the open access system of appointments as they were guaranteed to see the GP that day. Patients were generally happy to wait once arriving at the surgery.

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 found that the complaints procedure was advertised and available for patients to take away with them from the reception. Patients we spoke with were aware of the procedure but had never needed to use it.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at two complaints received over the last 12 months and found all to be responded to appropriately and in line with the practice policy. The complaints were reviewed by the GP and discussed in practice meetings to enable learning from the complaints.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

We found that the vision and values of the practice were not well developed. The practice met the need of the patients that came through the door for appointments but there was no detailed or realistic plans to achieve the vision, values and strategy. Staff were not involved in the development of the practice and there was no drive or the impetus to strive for continuous learning, improvement or innovation. However staff made it a priority to care for patients and meet the needs of the population on a day to day basis.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity which was available to staff. We viewed five policies and found them to be relevant to the operation of the practice. Policies were in date and due for renewal in February 2015. Responsible persons were assigned within the policies to all areas of governance within the practice. However there was some confusion amongst staff we spoke with over who was responsible for the governance of infection control and long term conditions management.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The data showed that overall the practice was performing below national standards; however we found no evidence that this performance was discussed within the practice and plans put in place to improve performance.

The practice had some arrangements for identifying, recording and managing risks. This was in the form of the significant events process which was not completed fully after each event with some events not recorded. The practice did not have a risk log to identify incidents and risks as they happen on a daily basis and there was limited evidence to show active learning by the practice as a result of complaints or incidents.

the governance arrangements and their purpose were unclear. The information that was used to monitor performance or make decisions was inaccurate or no monitoring of performance was taking place. There was no system to effectively manage infection control within the practice through no systems being put in place to ensure the building maintenance undertook the work to the standard required. There was no process in place for ensuring fire safety is checked and adhered to. Fire safety checks were left to the building maintenance company. There was a lack of risk assessment to show the reasoning as to why non-clinical staff did not receive a Disclosure and Barring Service (DBS) check which included the employed chaperone. No system was present for the testing and assessing the risk of legionella.

Although some clinical audits were being undertaken, there was no continuous audit cycle in process.

Leadership, openness and transparency

The leadership did not have the necessary knowledge or capability to lead effectively. Leaders were out of touch with what was happening during day-to-day services. There was a lack of clarity about authority to make decisions. We found that there was confusion over the leadership arrangements for chronic disease management within the practice. For example both the GP and nurse were of the understanding that the other was responsible for chronic disease management.

We found the practice had named members of staff who took the lead for areas such as infection control and safeguarding. We spoke with staff who were clear on their responsibilities, however there was a lack of clarity around the monitoring process.

The practice manager was responsible for the human resources policies and procedures. However, there were a number of shortfalls in the implementation of some policies and procedures including infection control, medicines management, implementation of Disclosure and Barring Service (DBS) checks and equipment checks including emergency equipment. We were shown a number of related policies, including the induction policy and staff training policy which were in place to support staff. Staff we spoke with knew where to find these if required.

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

The practice gathered feedback from patients through the annual patient survey. We looked at the results of the most recent survey results from March 2014. The results showed that only 35% of patients that completed the survey felt involved in decisions about their care which has been noted by the GP who was striving to improve this area

Are services well-led?

Inadequate

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

through talking through treatments more thoroughly with patients and outlining the options for treatment. Positively 91% were able to see the GP when they wanted and 87% liked the type of appointment system.

The practice had an active Patient Participation Group (PPG) with representatives from all the patient population groups. The PPG meet every three months with the practice management team to discuss issues of concern and any other updates provided by the practice management team, for example to discuss the implementation of a memory clinic at the practice. After discussion the PPG felt that it was not worthwhile as the service was available at the nearby hospital.

The practice gathered feedback from staff through team meetings and annual appraisals. Staff told us that they were comfortable in giving feedback to the practice manager and GP and were happy to discuss issues with colleagues and management.

The practice had a whistle blowing policy which was available to all staff. Staff we spoke with were aware of the policy but had not found cause to use it.

Management lead through learning and improvement

Staff told us that the practice supported continuous learning and development through training. However we were informed that finance was a restriction. We looked at staff files and found that regular appraisals had taken place which included a personal development plan.

The outcome of significant events, complaints and patient feedback were discussed in practice meetings to improve outcomes for patients. For example after a patient collapsed in the reception area needing emergency attention, the emergency policy was discussed in order to improve staff awareness and responsiveness to such incidents.

There was a lack of completed clinical audits and no evidence of an audit cycle to be used for learning and improving quality and outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Patients are not being fully protected from the risk of abuse because the practice had failed to ensure all chaperones had received a Disclosure and Barring Service (DBS) check.** **The practice did not carry out appropriate recruitment checks before staff commenced employment.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider did not have adequate temperature gauges on medicine fridges.** **The provider failed to act when fridge temperatures diverted from the safe temperature range.** **Vaccines were not stored safely within the medicine fridges in accordance with national guidelines.** **The provider did not keep accurate records of fridge temperatures.** **The provider failed to store prescription pads securely, and no system was in place to monitor their use.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider failed to use all current national guidelines for the treatment of patients with COPD.**

This section is primarily information for the provider

Compliance actions

There was confusion over the responsibility for managing long term conditions within the practice which may have resulted in patients not being treated effectively.

Adrenaline was missing from the emergency medicines bag.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Cleaning schedules were not held and maintained for the practice. The provider had not carried out testing or risk assessments for legionella.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The practice failed to ensure that all equipment was in date including blood bottles, hand wash gel and urine testing strips. A lack of governance resulting in areas such as cleaning and fire safety not being monitored by the practice and left to the building management company. The practice did not always follow the significant events process causing events to bot be recorded or the process to be incomplete. The practice did not have a risk log. No clinical audit cycle was present. No monitoring of the number of staff needed to meet patient's needs. No schedule held for checking the expiry date of equipment.