

Cassidy 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

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Requires improvement 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

The practice is rated as requires improvement

Our key findings were as follows:

- Patients were satisfied with access to the practice. There was a flexible appointment system, a weekend walk-in service and online consultations offered.
- Patients said the practice was caring and staff treated them with dignity and respect. They said clinical staff involved them in decisions about their care and treatment.
- On the day of our inspection the practice was clean, hygienic and well equipped.
- The practice had some governance arrangements in place and was supported by the providers corporate team.
- The practice actively sought patient's feedback and acted on it.

We found areas of outstanding practice including:

- The practice offered online consultations for a range of medical conditions allowing patients to receive advice or treatment from their home.
- The practice had a close working relationship with a local charity that offered community support to patients with non-medical needs. The practice attended regular meetings with the charity to identify patients who might benefit from this form of support. The charity offered a telephone counselling service for these patients.
- A weekend walk-in service was available accessible to patients who were unregistered.

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

Importantly, the provider must:

Summary of findings

- Share learning from significant events/complaints with all staff
 - Disseminate safety alerts to appropriate staff and ensure they are acted on
 - Hold regular clinical meetings to share best practice and learning from significant events/complaints
 - Carry out clinical audit to improve outcomes for patients
 - Ensure all patients with long-term conditions are reviewed appropriately
 - Develop care plans for all patients with complex needs
- Ensure all patients medical records are accurate and up to date

In addition the provider should:

- Ensure all staff are aware of the practice mission statement/aims and objectives
- Proactively offer health checks for patients over 40 years old and influenza vaccinations for 'at risk' patients

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 safe.

Safeguarding procedures were in place to protect children and adults from harm. Medicines were managed safely and staff were trained to respond to medical emergencies. The practice was clean and hygienic and infection control procedures were followed by staff.

Significant events were reported and analysed however learning was not shared with all staff and safety alerts received from the NHS were not disseminated and acted on.

The practice had health and safety risk assessments in place and where risks had been identified control measures were in place to minimise them.

The required pre-employment checks had been completed on all staff.

Requires improvement



Are services effective?

The practice is rated as requires improvement for effective.

Clinical staff had access to best practice standards and guidance however not all patients had their needs assessed and care planned in accordance with these. We found that the care for some patients fell short of effective practice putting them at risk of avoidable health problems. We viewed a sample of patient's case notes. Two out of five patient's had not had their long-term conditions reviewed and three out of five patients with complex needs did not have a care plan in place.

The practice was not carrying out regular clinical audits and using them in a systematic way to improve outcomes for patients.

The practice worked with other service providers to meet patients' needs. These included the palliative care team, mental health team, community health visitor, district nurse and tissue viability services.

We found no clinical meetings were held to share best practice standards and guidance.

We found where a Do Not Attempt Resuscitation (DNAR) had been agreed for a patient in a palliative care meeting there was no evidence of this decision in the patients case notes.

Health checks for patients over 40 years old and influenza vaccinations for 'at risk' patients were not proactively offered.

Requires improvement



Summary of findings

Are services caring?

The practice is rated as good for caring.

We spoke to 14 patients, received 27 completed Care Quality Commission (CQC) comment cards, and reviewed the results of the national patient survey 2014. Feedback showed that patients were satisfied with the services provided in terms of the practice being caring. Patients said staff treated them with dignity and respect and their privacy was respected.

Patients said clinical staff involved them in decisions about their care and treatment and consent was sought before physical examinations were carried out. GPs were able to demonstrate an understanding of Gillick competences when obtaining consent from children.

Patients were positive about emotional support provided by staff and the practice had a close working relationship with a local charity that offered community support to patients with social needs.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive.

The practice had recognised the needs of different groups in the planning of its services. This included a flexible appointment system and a weekend walk-in service which was accessible to patients who were unregistered. Online consultations were also offered through the practice website. Longer appointments and a named GP were available for older patients over 75 years and home visits for those who were housebound.

The practice was accessible to patients with mobility needs and an interpreter service was available to patients whose first language was not English to help them with their communication needs.

We found that 12 out of 14 patients we spoke to expressed concern about the lack of continuity of care at the practice. Patients were dissatisfied with the constant turnover of clinical staff and this caused them distress. This was also reflected in the completed Care Quality Commission (CQC) comment cards we received, feedback on the NHS Choices website and the national patient survey 2014 where the practice scored below both the CCG and national averages for patients with a preferred GP who usually got to see or speak to that GP.

The practice had a system in place for handling complaints and they had been responded to in a timely manner in line with the practices complaints procedure.

Good



Summary of findings

Are services well-led?

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

The practice had leadership and governance arrangements in place. Staff were clear on their level of responsibility and who to report to with any issues. The practice had a statement of purpose with clear aims and objectives however, staff we spoke to were not able to articulate these.

Staff said they were supported and listened to by managers however, we found no formal clinical meetings had been held in the previous nine months and two clinical staff were unaware of the clinical governance newsletter. Mechanisms for sharing clinical learning within the practice were weak.

Some systems were in place to monitor the quality of services provided however the practice was not carrying out regular clinical audits and using them in a systematic way to improve outcomes for patients.

The practice had a Patient Participation Group (PPG) to represent patients and regular internal surveys had been carried out to gain patients views of the practice. The practice monitored comments from patients on the NHS Choices website and responded to negative feedback.

Requires improvement



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for the population group of older people.

The practice was responsive to the needs of older people including longer appointments, personalised care plans and a named GP for those patients over 75 years. Home visits were available for older patients and a dedicated phone line was in place so homebound patients could contact the practice when necessary.

The practice had safeguarding procedures in place for older people. Staff had been trained in safeguarding vulnerable adults and were aware of the reporting procedures if they had any concerns.

Regular meetings were held to plan care and treatment for patients requiring end of life care. However we found that important decisions relating to them had not always been recorded in their case notes.

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

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the population group of people with long-term conditions.

The practice provided clinics for patients with a variety of long-term conditions including asthma, diabetes and chronic obstructive pulmonary disorder (COPD). We found that some patients with long-term conditions had not had their conditions reviewed putting them at risk of avoidable complications or deterioration. We reviewed five case notes of patients with long-term conditions and found two patients had not had a review in the previous 12 months. We found that a patient with diabetes had not been regularly reviewed for their condition despite attending a recent consultation for another condition commonly associated with diabetes.

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

Requires improvement



Summary of findings

Families, children and young people

The practice is rated as requires improvement for the population group of families, children and young people.

Services were available for this population group. The practice did not provide family planning clinics however pre and post natal support was provided by the GPs and nurse team. A wide variety of information was available on the practice website targeted at families, children and young people.

The practice referred patient's to a specialist service for HIV testing and treatment for sexually transmitted diseases.

Child immunisation/vaccination services were available in line with national guidelines. Data showed that the practice had scored below the CCG average for most immunisations in the previous year.

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

Requires improvement



Working age people (including those recently retired and students)

The practice is rated as requires improvement for the working-age people (including those recently retired and students).

The practice had a flexible appointment system including extended surgery hours on Wednesdays from 6.30pm to 7.30pm and a weekend walk-in service for patients requiring an appointment outside of normal working hours. The practice offered online registration and appointments and online consultations for a variety of conditions.

The practice had information on their website on a wide range of health conditions including information specific to men's and women's health. Smoking cessation clinics were not provided and patients were referred to a local smoking cessation service to help them quit smoking. The practice had not monitored how many of their patients referred to this service had successfully managed to stop smoking.

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

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable.

Requires improvement



Summary of findings

The practice supported patients living in vulnerable circumstances. There was a weekend walk-in service accessible to unregistered patients and those who were homeless.

The practice had a register of patients with learning disabilities and these patients were offered annual health checks. The practice had developed a template written in simple English with pictures to explain the importance of health checks and inviting patients in for an appointment with the GP to encourage them to access the service.

The practice had a close working relationship with a local charity that offered community support to patients with non-medical needs. The practice attended regular meetings with the charity to identify patients who might benefit from this form of support. The charity offered a telephone counselling service for these patients. The practice also supported the food bank scheme and was a designated supplier of food vouchers.

Home visits were available for patients who were housebound.

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

People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia).

The practice offered annual physical health checks for patients experiencing poor mental health however the practice was unable to provide data on how many patients had received one.

Non-attendances were followed up by staff. Staff had attended a training day covering mental health issues and reception staff knew to be flexible with patient's adherence to appointment times when appropriate.

The practice had scored above the national average for the percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months and the percentage of patients with physical and/or mental health conditions whose notes contain an offer of support and treatment within the preceding 15 months.

The practice had sign-posted patients experiencing poor mental health to support groups such as the local Mind team.

Requires improvement



Summary of findings

The practice had information on their website targeted at patients experiencing poor mental health. This included information on anxiety, depression, low mood and panic attacks. Information was also available on depression.

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

Summary of findings

What people who use the service say

We spoke with 15 patients during the course of our inspection including a representative of the Patient Participation Group (PPG). We reviewed 27 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service, information published on the NHS Choices website, the results of the practices most recent patient experience survey and the national patient survey 2014.

The evidence from all these sources showed patients were satisfied with their GP practice in terms of the practice being caring. Patients said they were treated with

dignity and respect by all the practice staff and said their privacy was respected. Patients said the clinical staff involved them in decisions about their care and treatments.

However, patients did express concern about the lack of continuity of care at the practice. Patients said they were unhappy with the constant turnover of clinical staff and this caused them distress. They did not want to discuss their medical conditions with a different GP at every appointment and this was reflected in all the sources of evidence we received.

Areas for improvement

Action the service MUST take to improve

Share learning from significant events/complaints with all staff

Disseminate safety alerts with appropriate staff and ensure they are acted on

Hold regular clinical meetings to share best practice and learning from significant events/complaints

Carry out clinical audit to improve outcomes for patients

Ensure all patients with long-term conditions are reviewed appropriately

Develop care plans for all patients with complex needs

Ensure all patients medical records are accurate and up to date

Action the service SHOULD take to improve

Ensure all staff are aware of the practice mission statement/aims and objectives

Proactively offer health checks for patients over 40 years old and influenza vaccinations for 'at risk' patients.

Outstanding practice

The practice had recently started offering an online consultation service provided through the Hurley Clinical Partnership. This allowed patients to contact the practice via an interactive web form. The system incorporated safety checks and had the potential to reduce unnecessary consultations.

The practice had a close working relationship with a local charity that offered community support to patients with

non-medical needs. The practice attended regular meetings with the charity to identify patients who might benefit from this form of support. The charity offered a telephone counselling service for these patients.

A weekend walk-in service was available accessible to patients who were unregistered.

Cassidy Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. It included a GP, a practice manager and an expert-by-experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. They were all granted the same authority to enter Cassidy Medical Centre as the Care Quality commission (CQC) inspector.

Background to Cassidy Medical Centre

Cassidy Medical Centre operates from 651A Fulham Road, London, SW6 5PX. The practice provides NHS primary medical services through an Alternative Provider Medical Service (APMS) contract to 4800 patients in the Fulham area. The practice is part of the NHS Hammersmith and Fulham Clinical Commissioning Group (CCG) which is made up of 31 GP practices. The practice serves a young population group with patients predominantly in the 20 to 40 years age range. The practice staff comprise of a female salaried GP, a male long-term locum GP, two locum practice nurses covering the full time nurse currently on maternity leave, a practice manager and a small team of non-clinical staff. The practice partnership also runs its own bank of locum GPs to cover clinical sessions when needed. The practice is managed as part of the Hurley Clinical Partnership with over 20 practices located across London and additional support is provided to the practice by the Hurley Clinical Partnership corporate team.

The practice opening hours are 8.00am to 6.30pm Mondays and Fridays and 7.00am to 6.30pm Tuesdays, Wednesdays

and Thursdays with extended hours until 7.30pm on Wednesdays. The practice is also open from 8.00am to 12.00pm on Saturdays and provides a walk-in centre between 9.00am and 4.00pm on Saturdays and Sundays for patients with minor or moderate illnesses. The practice has opted out of providing out-of-hours services to their own patients and refers patients to the '111' service. The practice has an electronic prescription service and operates an online service which enables registered patients to obtain advice and consult with a GP via an interactive web form.

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 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?

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice including information published on the NHS choices website and the national patient survey 2014 and asked other organisations such as Healthwatch, NHS England and NHS Hammersmith and Fulham Clinical

Commissioning Group (CCG) to share what they knew about the service. We carried out an announced visit on 2 October 2014. During our visit we spoke with a range of staff including two locum GPs, a locum nurse, the practice manager, three non-clinical staff and three members of the corporate team. The salaried GP was not present during our inspection. We spoke with 15 patients who used the service including a representative of the Patient Participation Group (PPG). We reviewed 27 completed Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe Track Record

The practice had systems in place to identify risks but there were shortcomings in the way the practice managed patient safety. There were procedures for reporting, recording and monitoring significant events which were being followed by staff and also for learning from patient feedback and complaints. Staff were aware of accident reporting procedures and when to use the accident report book. The practice received national NHS patient safety alerts but did not have an effective system in place to ensure these were acted upon.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant events were logged online and reviewed centrally by the corporate clinical governance team. We reviewed four significant events reported since February 2014. The details of each incident had been recorded and the appropriate action taken. For example a staff member had suffered a needlestick injury. The correct procedure was followed in line with practice procedure to ensure any risks were mitigated. Learning from significant events was documented in a section of the Hurley Group newsletter which was distributed to each practice in the organisation. However two locum staff members said they were not aware of the newsletter and had not read it.

Safety alerts received from the NHS central alerting system had not been distributed to relevant staff members and acted on. We were shown two safety alerts received by email. The practice manager told us she had not been instructed on how to deal with them and as a consequence they had not been disseminated to appropriate staff and acted on.

Reliable safety systems and processes including safeguarding

The practice had policies and procedures for protecting both children and adults from harm. There was a designated GP responsible for child protection and safeguarding adults. Clinical staff had completed child protection training to Level 3 and non-clinical staff to Level 1. All staff had completed training in safeguarding vulnerable adults. Staff were able to describe the reporting

procedures if they had concerns about a patient and the local safeguarding team contact details were available for staff to access. Staff were alerted to children on the at risk register through the practices electronic record system.

A whistleblowing policy was in place to protect patients from the risks associated with bad practice and staff were aware of whistleblowing procedures.

A chaperone policy was in place and was displayed for patients to view. Staff had been trained to act as chaperones which allowed for patients to have a third party present during a consultation, or medical examination if they so wished. Both clinical and non-clinical staff acted as chaperones and Disclosure and Barring Service (DBS) checks had been completed for all staff acting in this capacity.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Daily checks were carried out on the refrigerators to ensure vaccines were stored within the correct temperature range. We noted that all vaccines were stored appropriate temperatures.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of appropriately. No controlled drugs were stored at the practice.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. Repeat prescriptions could be ordered online or in person at the practice and were available for collection within 48 hours. Prescription pads were stored securely.

Cleanliness & Infection Control

During our inspection we found the practice to be clean, hygienic and tidy. There was a cleaning schedule displayed in the practice for cleaning staff to follow. Consultation rooms had an adequate supply of soap, paper towels and disinfectant wipes. Antibacterial hand gel was accessible throughout the practice for staff and patients to use. Hand hygiene techniques signage and needlestick injury protocols were displayed in clinical areas as a quick

Are services safe?

reference for staff. Waste was stored appropriately and disposed of by a professional waste company. We saw records showing that staff Hepatitis B immunisations were up-to-date.

The practice had an infection control policy in place and clinical staff had completed infection control training on an annual basis. A locum nurse and practice manager shared the lead for infection control to ensure procedures were followed by staff. The practice had completed an infection control audit in September 2014 to monitor standards. There were no areas identified for improvement.

The practice had a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

The practice used medical equipment that was fit for purpose. We viewed records which showed that all medical equipment had received calibration checks in the previous 12 months in line with the practice's calibration policy. Equipment included spirometers, thermometers, a defibrillator, nebulisers, weighing scales and the fridges where vaccinations and immunisations were stored. PAT (portable appliance) testing of all portable electrical equipment was also completed annually. We saw evidence that other essential equipment such as fire extinguishers and fire alarms were regularly checked and serviced in line with the practice's fire policy.

Staffing & Recruitment

The practice staff comprised of a full time female GP, a full time long-term locum male GP, two locum nurses covering for the full time practice nurse who was on maternity leave, a practice manager and three reception/admin staff. Locums were used to cover sessions in response to demand. The practice staff were also supported by the Hurley Group corporate team. The practice was experiencing a period of transition since two full time GPs left the practice in April 2014 and patients were not satisfied with the continuity of care. We were informed by a member of the corporate team that a new full time male GP would commence employment at the practice on 8 October 2014 and they would replace the long-term locum to further stabilise staff turnover.

We were shown the recruitment process by a member of the corporate team. Pre-employment checks were completed by the human resources department of the Hurley Group. The information was held centrally on the corporate computer system. We found that all the necessary pre-employment checks had been completed on staff working at the practice. These included Disclosure and Barring Service (DBS) checks, evidence of professional registration where appropriate, Hepatitis B status and satisfactory references. The practice utilised the Hurley Group's own bank of locums and had developed a locum pack which was detailed and included information about the practice policy and procedures.

Monitoring Safety & Responding to Risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. These covered risks associated with the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had health and safety risk assessments in place and where risks had been identified control measures were in place to minimise them. Plans were in place to manage staff shortages including the use of locums to cover staff absence due to illness, annual leave or maternity leave.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff had completed training in responding to medical emergencies. This included Cardio-Pulmonary Resuscitation (CPR) and defibrillator training for all staff and anaphylaxis management for clinical staff. Practice training records showed that staff training was up-to-date. Protocols were available in the practice as a quick reference for staff. All the consultation rooms had a protocol for the management of anaphylaxis so clinical staff could act promptly in the event of an emergency. Emergency equipment was available including access to an oxygen cylinder, automated external defibrillator (used to

Are services safe?

attempt to restart a person's heart in an emergency) and a nebuliser for asthma. Staff knew the location of this equipment and records confirmed they were checked regularly to ensure they were in date and fit for use.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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.

Staff had received fire and marshal training to ensure staff and patients could be evacuated safely in the event of a fire and the practice's fire evacuation procedure was displayed for staff and patients to follow.

The practice had a business continuity plan in place which identified potential risk to patients including foreseeable emergencies such as IT failures and disruption to the facilities due to flood or fire. The plan set out how each of these risks would be managed to minimise the risk to patient care.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All GPs we interviewed had online access to the National Institute for Health and Care Excellence (NICE) primary care guidelines and primary care journals to keep their knowledge up-to-date. The GPs were aware of their professional responsibilities to maintain their knowledge. However new guidelines and updates were not systematically shared across the clinical team and the implications for the practice and patients discussed.

We found that not all patients had their needs assessed and care planned in accordance with clinical best practice. We reviewed five case notes of patients with long-term conditions and found that some patients had not had their conditions reviewed putting them at risk of avoidable complications or deterioration. Specifically we found two out of five patients had not had their long-term conditions reviewed in the previous 12 months and the practice had not invited them in for a review. We also found that a patient who registered at the practice in 2011 with diabetes had not had a review of their condition since registering despite receiving a consultation in March 2014 for another condition commonly associated with diabetes.

We also reviewed five case notes of patients with complex needs. We found that three patients had no care plan in place although it had been coded in their notes that a care plan had been agreed.

Clinical Commissioning Group (CCG) data showed that the practice was performing in line with CCG standards on referral rates.

Management, monitoring and improving outcomes for people

The practice had achieved target in their Quality and Outcomes Framework (QOF) performance in the year ending April 2014. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. QOF performance was compared across all the practices managed by the Hurley Group and weekly QOF updates were sent out by the corporate team.

We saw evidence that the practice had participated in medication audits carried out by the Clinical

Commissioning Group (CCG) and had carried out an internal audit of referrals. Some actions for improvement had been identified as a result of the referrals audit however the audit cycle was incomplete. That is, the audit had not been repeated to check that performance had improved. The practice was not carrying out a planned programme of clinical audit and was not systematically using audit evidence to improve outcomes for patients. Both locum GPs we spoke to and the practice manager were unaware of any regular clinical audits done internally at the practice. We were unable establish if the full time female GP had carried out any clinical audits as they were not working at the practice on the day of our inspection.

Effective staffing

A full time female GP, a long-term locum GP and two locum practice nurses worked at the practice. In addition a locum bank was used to cover sessions as required. We reviewed a number of staff files including both clinical and non-clinical staff held on the Hurley Group computer system. They demonstrated that staff had the appropriate skills and qualifications to meet patients' needs. The GPs were registered by the GMC and the nurses registered with the Nursing and Midwifery Council (NMC). Staff including locum staff had completed an induction programme when they started working for the practice. All staff had received regular mandatory training in a wide range of topics. Topics included health and safety, equality and diversity, basic life support, child protection, safeguarding adults, infection control, information governance and computer training.

All staff had completed annual appraisals. The appraisal cycle included objectives for staff to achieve within a specific timeframe. Staff told us they were actively encouraged to develop and contribute to their personal development plans. GPs were up to date with the General Medical Council (GMC) requirement for revalidation. The full time GP had completed revalidation in May 2014 and the long-term locum GP had completed revalidation in 2013.

Working with colleagues and other services

Blood results and hospital discharge letters were received electronically and dealt with within 24 hours. Hospital letters were reviewed by the GPs and dealt with according to need and outpatient letters were reviewed within 5 days of receipt. Information from the out-of-hours/111 providers was also received electronically.

Are services effective?

(for example, treatment is effective)

The practice held monthly palliative care meetings with other service providers to plan care for patients with end of life care needs. We saw evidence that the practice worked with the local mental health team, community health visitor, district nurse and tissue viability services.

The practice was part of a Clinical Commissioning Group (CCG) local network of five practices. Meetings were held monthly and attended by the practice manager and the lead GP. The practices supported one another and discussed issues, benchmarked outcomes and conducted peer review. We reviewed meeting minutes and found topics discussed included referrals, prescribing issues, medicine management, virtual ward, IT issues and NHS health checks.

Information Sharing

Patients were referred to other services/specialists through the Choose and Book service. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 for example when recording requests around Do Not Attempt Resuscitation (DNACPR). However, we found that where a DNAR had been agreed for a patient in a palliative care meeting there was no evidence of this decision in the patient's case notes.

GPs we spoke to were able to demonstrate an understanding of Gillick competencies and Fraser guidelines to obtain consent from children, legislation used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge.

Health Promotion & Prevention

The practice provided a range of health promotion services including child immunisation, travel vaccination, diabetes, asthma and COPD clinics. The practice also provided pre and post natal support with the GPs and nurses.

The practice offered all new patients registering with the practice a health check with a nurse and informed the relevant GP if any concerns were detected. The practice offered NHS health checks to all its patients aged over 40 years however data was not available on how many patients had received one. We found that these health checks were not proactively offered.

The practice had identified the smoking status of 69.9 % of patients over the age of 16. The practice did not provide smoking cessation clinics however appropriate patients were referred to an NHS funded smoking cessation service operating in the local area. The practice did not monitor the number of patients referred to this service who had successfully stopped smoking.

The practice referred patient's to a specialist service for HIV testing and treatment for sexually transmitted diseases.

The practice offered influenza vaccinations to all patients identified at risk. However this service was carried out on an ad hoc basis. No letters had been sent out inviting patients in for a vaccination. This was reflected in data we received from the Health & Social Care Information Centre where the practice scored below the national average for the percentage of patients aged over 6 months to under 65 years in the defined influenza clinical risk groups that received the seasonal influenza vaccination.

The shingles vaccination was offered according to national guidance to older people. We found the Human Papilloma Virus (HPV) vaccination was not currently offered. Cervical screening was offered and letters sent out with a 67.4 % patient coverage. The practice provided travel vaccinations but was not a designated provider for yellow fever vaccination.

A child immunisation/vaccination service was available and national guidelines were followed. Child immunisations were offered at the required one, two and five year intervals. Data showed that the practice had scored below the CCG average for most immunisations in the previous year.

The practice had a register of patients with a learning disability however data was not available on how many of these patients had received an annual physical health check.

The practice had information on their website on a wide range of health conditions including information specific to

Are services effective?

(for example, treatment is effective)

men's health, women's health and mental health. We also found the practice had a variety of information leaflets available in the waiting area of the practice to help patients make informed decisions about their care and treatment.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014, NHS Choices feedback, a survey of over 100 patients carried out by the practice between January and March 2014 and patients we spoke to during our inspection. Patients also completed Care Quality Commission (CQC) comment cards to provide us with feedback on the practice.

The evidence from all these sources showed patients were satisfied with their GP practice in terms of the practice being caring. This was reflected in the national patient survey 2014 where the practice scored in line with the national figures for the proportion of respondents who described the overall experience of their GP surgery as 'fairly good' or 'very good'.

All 14 patients we spoke to said they were treated with dignity and respect by the practice staff and their privacy was respected. We received 27 completed cards and the majority were positive and said the staff were empathic to their needs. This was reflected in the national patient survey 2014 which showed the practice scored in line with the national figures for patients saying the last time they saw or spoke to a GP or nurse they were treated with care and concern.

Patients said that all consultations and treatments were carried out in the privacy of a consultation room and their private conversations could not be overheard. Disposable curtains were provided in consultation and treatment rooms to maintain patients' privacy during examinations and treatments.

Care planning and involvement in decisions about care and treatment

Patients said the clinical staff involved them in decisions about their care and treatments and this was reflected in the comment cards we received. The results of the National

Patient Survey 2014 showed the practice scored in line with national figures for patients saying the last GP or nurse they saw or spoke to was good at involving them in decisions about their care.

Patients said that clinical staff sought their consent before carrying out physical examinations. Patients said the GPs discussed treatment options including the pros and cons of different treatments before a decision was made about their treatment or care. GPs were able to demonstrate an understanding of Gillick competency assessments of children and young people. Gillick competency guidelines help clinicians decide whether a child under 16 years has the legal capacity to consent to medical examination and treatment without the need for parental permission or knowledge.

GPs had a working knowledge of the Mental Capacity Act 2005.

An interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection were positive about the emotional support provided by staff at the practice and this was reflected in the CQC comment cards we received.

The practice had a close working relationship with a local charity that offered community support to patients with non-medical needs. The practice attended regular meetings with the charity to identify patients who might benefit from this form of support. The charity offered a telephone counselling service for these patients. The practice also supported the food bank scheme and was a designated supplier of food vouchers.

We were told that condolence letters were sent out to patients whose relative had passed away.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice provided a variety of options to meet the needs of its patient groups. For example a range of appointments were available. Patients could make an appointment by phone, online or in person. Extended hours were available on Wednesdays and online consultations could be accessed via the practice website. The practice offered a weekend walk-in service accessible to vulnerable groups who were not registered with the practice and a named GP and double appointment slots for older patients over 75 years. Home visits were also available for those patients who were housebound.

There had been a high turnover of staff during the previous nine months which had impacted the continuity of care and accessibility to appointments with a GP of choice. We found that 12 out of the 14 patients we spoke to said they were concerned about seeing a different GP each time they attended their appointments. Patients said that it caused them distress and they felt there was a lack of continuity of care. They were unhappy about explaining their medical conditions to different GPs at every new appointment. These concerns were also reflected in the CQC comment cards we received, NHS Choices feedback and the national patient survey 2014 where the practice scored below the CCG and national averages for patients with a preferred GP who usually got to see or speak to that GP.

A member of the corporate team told us that the practice had relied a lot on locum GPs and nurses since two full time GPs left in April 2014 and the practice nurse went on maternity leave. However we were told a new full time GP was starting at the practice from 8 October 2014 which would improve the continuity of care for patients.

The practice had a Patient Participation Group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. We spoke with a representative of the PPG who explained their role and how they worked with the practice. The PPG consisted of approximately 6 members which was a mixture of male and female patients between the age of 30 and 80 years old. The PPG met with the practice on a regular basis and was involved in the patient survey conducted in 2014. The practice had formulated an action plan in agreement with

the PPG and some areas for improvement had been implemented. For example the practice had introduced online consultations on their website to improve access for patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the practice provided annual health checks for patients with learning disabilities and had developed a template written in simple English with pictures to explain the importance of health checks and inviting patients in for an appointment with the GP. The practice provided a weekend walk-in service and this was accessible to unregistered patients including those who were homeless.

The premises and services had been adapted to meet the needs of people with disabilities. For example the entrance to the practice had a built in ramp to allow patients with mobility scooters and wheelchairs to access the practice and the toilet facilities had been modified to accommodate them. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the consultation rooms. There was a hearing loop at reception for patients who were hard of hearing and the practice made use of an interpreter service to ensure patients whose first language was not English could access the service. We also found staff had completed training in equality and diversity.

Access to the service

All of the patients we spoke to said they could get an appointment when they wanted one. This was reflected in the CQC comment cards we received and the national patient survey 2014 where the practice scored above the CCG average for ease of getting through to the practice by telephone, convenience of appointments and the time patients waited to be seen by a GP after their appointment time. This also compared positively in comparison to national data where the practice scored above the national average for the percentage of patients who were 'very satisfied' or 'fairly satisfied' with their GP practice opening hours.

The practice opening hours were 8.00am to 6.30pm Mondays and Fridays and 7.00am to 6.30pm Tuesdays, Wednesdays and Thursdays with extended hours until 7.30pm on Wednesdays. The practice was also open from 8.00am to 12.00pm on Saturdays and provided a walk-in

Are services responsive to people's needs?

(for example, to feedback?)

centre between 9.00am and 4.00pm at weekends for patients with minor or moderate illnesses. The walk-in centre was accessible to unregistered patients. Routine appointments were bookable from 48 hours up to six weeks in advance. Urgent appointments were available on the same day and home visits could be arranged if the patient called before 10.00am on the day they needed to see a GP. The practice had recently introduced an online service which allowed patients registered with the practice to consult with a GP through an online form. The practice website outlined how patients could book appointments and organise repeat prescriptions. Appointments were bookable by phone, in person or online. An online prescription service was also available and prescriptions were made available within 48 hours.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hour's service. Information on the out-of-hours service was provided to patients and there was an online 24/7 service where patients could request a call back from the 111 emergency and urgent care services.

Listening and learning from concerns & complaints

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

Accessible information was provided to help patients understand the complaints system in the form of a leaflet held at reception. We reviewed the complaints file and found the practice had received three complaints in 2014. These complaints had been dealt with appropriately in line with the practice's complaints policy. We saw evidence of shared learning from complaints with staff via the corporate newsletter. However not all staff were aware of the newsletter. We also found that negative feedback posted on the NHS Choices website was discussed in monthly reception/administrative staff meetings and learning shared.

Are services well-led?

Requires improvement 

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

Our findings

Vision and Strategy

The practice had a statement of purpose in place. This was a commitment to provide patient centred care of high quality in a safe and comfortable environment. Although the practice had clear aims and objectives staff members we spoke with were not able to articulate them and the statement of purpose was not displayed for patients and staff to view. A GP we spoke to was not aware of the practice's mission statement.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the corporate intranet site of the Hurley Group. We saw examples of policies. Staff had received regular updates and the policies were reviewed annually.

The practice used the quality and Outcomes Framework (QOF) to monitor their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed and analysed by the corporate team. QOF updates were sent to the practice by the corporate team on a weekly basis for the practice to focus on areas for improvement.

We saw evidence of medication audits carried out by the Clinical Commissioning Group (CCG) and one audit of referrals with some improvements identified. However we found no evidence that the practice was carrying out regular clinical audits and using them in a systematic way to improve outcomes for patients. Both GPs we spoke to and the practice manager were unaware of any regular clinical audits done internally at the practice. We were unable to establish if the lead GP at the practice had carried out any clinical audits as they were not working at the practice on the day of our inspection.

Leadership, openness and transparency

The practice had a clear leadership structure in place which had named members of staff in lead roles. For example there was a lead GP for child protection, safeguarding adults and clinical governance. The lead for infection control was shared between the practice manager and a locum nurse whilst the practice nurse was on maternity leave. We spoke to seven members of staff who were clear on their roles and responsibilities and who to report to with

any concerns. The clinical and non-clinical staff we spoke to said they felt the managers listened to them. There were clear lines of accountability. Reception/administrative staff reported to the practice manager who was accountable to the Hurley Group regional manager. Clinical staff reported to the lead GP who was accountable to the Medical Director and GP Partners.

We saw from minutes that reception/administrative staff meetings were held monthly however there had been no formal clinical meetings held at the practice for the previous nine months. The practice manager confirmed this was the case.

Practice seeks and acts on feedback from users, public and staff

The practice had gained feedback from patients through patient surveys, a suggestion box located at the reception, the NHS Choices website and complaints. We reviewed the results of a patient survey carried out between January and March 2014. The practice received over 100 responses to the survey. An action plan had been formulated based on the survey and some action points had been addressed. For example the practice had introduced an online consultation service to improve access to the GPs and had displayed the results of the survey in the reception area as requested by patients. The practice was responsive to comments on the NHS Choices website and had responded to complaints in line with practice policy. Learning from complaints was shared with staff through a corporate newsletter and feedback from the NHS Choices website shared at reception/administrative staff meetings. However two clinical staff members we spoke with were not aware of the newsletter.

The practice had a patient participation group (PPG) with approximately six members. The PPG consisted of male and female representatives between the age of 30 and 80 years old. The practice openly advertised for PPG members with a view to increasing the number of members. The last patient survey in 2014 had been carried out in conjunction with the PPG. The results and actions of these surveys were available on the practice website for patients to view and improvements made as a result.

Management lead through learning & improvement

Staff told us they were supported by the practice manager. Staff were given annual appraisals, which included clear

Are services well-led?

Requires improvement 

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

objectives and a timeframe for completion. Staff told us they were adequately supported with mandatory training and training specific to their job role. Monthly meetings were held to provide support, training and updates for the practice managers within the Hurley Group of practices.

The Hurley Group ran a talent management programme which provided training and mentorship support to new staff and to existing staff who wished to develop their skills and seek promotional opportunities within the group.

There was an online system for logging significant events and they were analysed by the clinical governance team of the Hurley Group. Bi-monthly clinical governance meetings were held by the Hurley Group where clinical and safety issues were discussed and these were attended by the lead GP. Learning from significant events and complaints were shared with the practice through a newsletter however not all staff were aware of the newsletter. The practice had not held clinical meetings to share learning from significant events.

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	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment because accurate records were not always kept in relation to their care and treatment. Regulation 20 (1) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment because learning from significant events and complaints had not been shared with all staff, safety alerts had not been disseminated and acted on, there was no evidence of completed clinical audit cycles and no clinical meetings held. Regulation 10 (1) (a) (b)