# The Groves Medical Centre

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

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

We carried out an announced comprehensive inspection at The Groves Medical Centre on12 May 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was rated as requires improvement for providing safe services. It was rated as requires improvement for providing services to the population group for People whose circumstances may make them Vulnerable, and rated as good for the remaining five population groups we report on: Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); and People experiencing poor mental health (including dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed, however not all risk assessments were recorded.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- There was a good skill mix amongst doctors and nursing staff with a number of clinicians having specialised areas of expertise.
- Patients said they were treated with compassion, dignity and respect by the doctors, and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice could evidence positive outcomes for patients as a result of audits they had completed.
- The practice achieved 895 points out of a total of 900 for the year 2013/14 (four percentage points above CCG Average and six above England Average).

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- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for bookable appointments.
- The practice held regular clinical and non-clinical meetings and minutes were recorded.
- The practice had sought feedback from staff and patients, and had acted upon that feedback.
- The practice had achieved above the CCG and national average for childhood immunisations.
- The practice fell below the CCG and national average for the number of patients who were satisfied with the appointment system and the ease of getting though on the phone.
- Not all staff were aware where emergency equipment was located, and some equipment was out of date.
- The practice fell below the CCG and national average for flu vaccinations for patients over 65 years and for those under 65 years in the defined influenza clinical risk groups.
- A review of patient records indicated there was room for further development of care plans.
- There were no clear lines of delegation to ensure key tasks were performed when principal staff were absent.

We saw one area of outstanding practice:

- The practice offered work placements to students from the local Council apprenticeship scheme. These apprentices are enabled to gain a range of skills and training. If they showed an aptitude for the work, where possible they would be offered a permanent position with the opportunity for further training and development. Current and former apprentices who were now permanent employees spoke highly of the opportunities provided by the GP practice.

There were areas of practice where the provider needs to make improvements.

Importantly the provider must:

- Ensure all equipment is within its use by date.
- Ensure all staff know where to find the emergency medicines and nebulisers.
- Ensure health and safety risk assessments are documented.

In addition the provider should:

- Ensure all clinical staff receive clinical alerts and minutes of clinical meetings.
- Record the action taken as a result of learning from significant events.
- Introduce a process for checking that equipment in GP bags is correctly maintained and all doctors are aware of and follow the practice policy regarding medicines in those bags.
- Record minutes of the practice governance meetings.
- Ensure the complaints leaflet is on display in the reception area.
- Ensure certificates relating to staff training are available.
- Carry out annual basic life support training.
- Ensure there are clear lines of delegation to provide a continuity of service when staff are absent.
- Ensure appropriate care plans are in place where there is an identified need for them.
- Ensure that patients with a learning disability receive an annual review.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However there was no record to indicate that action had been taken when learning points had been identified. Although risks to patients who used services were assessed, some of these assessments were not recorded, for example with regard to health and safety. The practice had appropriate equipment in place to deal with medical emergencies however this was stored in a range of locations and not all staff were aware where items were kept.

We found that staff were allocated key tasks, which they performed well however there were no clear lines of delegation to ensure these tasks were carried out in the absence of the key task holder. For example, one practice nurse held the responsibility to ensure the temperature of the vaccine refrigerators were checked daily however when they were not on duty remaining staff had no clear idea who would carry out this task.

With one exception we found that all portable equipment had been tested and appropriately calibrated however we also found out of date syringes and needles.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data showed most patient outcomes were at or above average for the locality although the practice had achieved a below average outcome for flu vaccinations for patients aged over 65 years and also for those under 65 years who were in a high risk category. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely.

A review of patient records indicated (in the records we saw) that patients who required one had a care plan in place however these could be further developed. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals for staff that had been in post for a year or more. Staff worked with multidisciplinary teams and regular meetings were held.

There were completed audits of patient outcomes and we saw evidence that audit was driving improvement in performance to improve patient outcomes.

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**Are services caring?**

Good

The practice is rated as good for providing caring services. Data from the national patient survey 2015, the Friends and Family Test and from the CQC comment cards showed that patients rated the practice well 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, and maintained confidentiality.

**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 and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified, although the practice could not give specific evidence of such improvements. Patients said urgent appointments were usually available the same day. Whilst patient feedback was below the CCG and national average with regard to the ease of making an appointment; being able to see a GP of choice and being able to get through on the phone, the practice had listened to this feedback. It had added additional telephone lines and was planning a four consultation room extension.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was easy to understand, although the complaints leaflet was not on display, and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and the Patient Reference Group.

**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a documented leadership structure and designated staff led in specific areas such as safeguarding, infection control and complaints. Staff felt supported by management however there were no clear lines of delegation to ensure key tasks were carried out when the designated member of staff was absent.

The practice had a number of policies and procedures to govern activity and held regular governance meetings although these were not recorded. There were weekly clinical and non-clinical meetings and these were minuted. There were systems in place to monitor

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and improve quality. The practice proactively sought feedback from staff and patients, which it acted on. The patient reference group (PRG) was small but active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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## The six population groups and what we found

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

### Older people

Good

The provider was rated as good for the care of older people.

The practice had a lower percentage of patients over the ages of 65 (13.5%) and 75 (6.4%) than the national average – 16.7% and 7.6% respectively. The income deprivation level affecting older people was 13 compared to the England figure of 22.5.

Nationally reported data showed that most outcomes for patients were in line with the national average for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population, for example all patients over the age of 75 had a named GP. The practice had signed up to the Avoiding Unplanned Admission enhanced service. In the records we reviewed we saw the patients who were part of this enhanced service had a care plan however these could be further developed. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice was the sole provider of GP care at five local nursing and residential homes, and feedback from them was positive with regard to the caring and responsive nature of the doctors. All homes appreciated having a named GP for their regular clinics.

The practice told us they had close working relationships with District Nursing, the Community matron, the Impact team and the Rapid Response Team. They signposted patients who required further advice and care to social care services, voluntary groups; and made onward referrals to other professionals such as pulmonary rehabilitation services, speech and language services and dietetics.

### People with long term conditions

Good

The provider was rated as good for the care of people with long term conditions.

The percentage of patients at the practice with a long standing health condition or with health related problems in daily life were 46.3% and 35.2%. These were lower than the England averages of 54% and 48.8%. There was a lead GP for each LTC. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. For example there was a diabetic service lead GP and nurse. The practice offered insulin initiation and access to an on-site dietician. There were 665 patients on the diabetes register of whom 154 were insulin dependent.

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The practice had increased its nursing complement and had respiratory specialists to provide a service to patients with chronic obstructive pulmonary disease (COPD). The practice had 188 patients on its COPD register, and 865 patients with asthma. We were told these patients were invited to attend for a review between September and November to try to minimise respiratory problems that became more prevalent in the winter months. Where appropriate these patients were supplied with emergency medicines.

Longer appointments and home visits were available when needed. All these patients had a named GP and were invited to a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. All cancer patients received a review from their named GP shortly after diagnosis and we were told the senior partner telephoned every patient with a new diagnosis.

**Families, children and young people**

Good

The provider was rated as good for the care of families, children and young people.

The practice had more children aged 0 to 4 (6.5%) and 5 to 14 (14%) than the England averages of 6% and 11.4%. The income deprivation level affecting children was 11 compared to the national level of 22.5. Both pre and ante natal care was provided by the doctors and visiting midwives. A health visitor was attached to the practice and was available for advice and clinics.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice offered contraceptive advice and a sexual health service and where appropriate patients could have coils or implants inserted. Chlamydia and HIV testing and advice was available.

There was a designated GP who led on child protection.

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

Good

The provider was rated as good for the care of working age people (including those recently retired and students).

# Summary of findings

The number of working age patients at the practice was comparable to the England average. The percentage of patients with a caring responsibility was lower than the national average at 13% compared to 18.2%. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered some online services including repeat prescriptions. Telephone consultations were available, and we were told patients could register to view their test results online, although we could not find details of this service on the practice website.

Extended hours, including phlebotomy, were available for appointments early on Tuesdays and Thursdays at 7.00 am, and until 8.00pm on Wednesdays. Patients could book an NHS health check online, and the practice offered temporary registration for students. Students were offered meningococcal meningitis boosters prior to university and Measles, Mumps and Rubella vaccination if required.

Patients could contact the practice via email if they found this easier.

**People whose circumstances may make them vulnerable**

**Requires improvement**

The provider was rated as requires improvement for the care of people whose circumstances may make them vulnerable .

The practice held a register of patients living in vulnerable circumstances including homeless people, patients with an addiction and those with a learning disability. It offered annual health checks for people with a learning disability however only seven out of 21 of these patients had received such a check-up. It offered longer appointments for people with a learning disability. The practice prescribed for methadone users and also provided services for alcohol dependent patients.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

**Good**

The provider was rated as good for the care of people experiencing poor mental health (including people with dementia).

Data from QOF indicated the practice exceeded the national average for having a comprehensive care plan in place for patients with schizophrenia, bipolar affective disorder and other psychoses achieving 96% compared to the national average of 86%.

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The practice liaised closely with the community mental health team (CMHT) and offered onsite counselling including Cognitive Behavioural Therapy. Support was offered to families and carers of patients with poor mental health and they were signposted to other organisations and groups who could offer further help.

Annual physical and checks and MH reviews were offered and 80% of these patients had had a review in the past year. The onsite pharmacy could supply medicines on a weekly basis and in blister packs where this was appropriate to aid compliance and avoid harm. The computer system would flag up to receptionists if a patient with a mental health illness wanted an appointment, and patients who required a double appointment were offered one.

The practice had improved its dementia diagnosis rate from just below 19% (national average 54%) to over 50% by providing an increased level of cognitive screening.

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## What people who use the service say

We spoke with five patients on the day of the inspection, and two members of the Patient Reference Group. All were generally positive about the practice and their experiences of the services provided with the exception of the appointment system and difficulties getting through on the phone. We received 37 comment cards. Of these 31 were very positive, with patients commenting, for example, that the care was excellent; staff friendly and respectful and the premises were clean and hygienic. Six cards contained both positive and negative comments. The negative comments were exclusively in relation to the difficulty in making/getting an appointment.

The National Patient Survey 2015 indicated patients rated the practice slightly above the CCG average for being involved by the GP in decisions about their care and for the GP explaining care and treatment. It was also above the CCG average for the number of patients who would recommend the practice to others. However it fell below the CCG averages in, for example, patients being able to see their preferred GP; for ease of getting an appointment; for the GP giving the patients enough time and for the nurse listening to patients.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure all equipment is within its use by date.
- Ensure all staff know where to find the emergency equipment.
- Ensure health and safety risk assessments are documented.

**Action the service SHOULD take to improve**

- Ensure all clinical staff receive clinical alerts and minutes of clinical meetings.
- Record the action taken as a result of learning from significant events.
- Introduce a process for checking that equipment in GP bags is correctly maintained and all doctors are aware of and follow the practice policy regarding medicines in those bags.
- Record minutes of the practice governance meetings.
- Ensure the complaints leaflet is on display in the reception area.
- Ensure certificates relating to staff training are available.
- Carry out annual basic life support training.
- Ensure there are clear lines of delegation to provide a continuity of service when staff are absent.
- Ensure appropriate care plans are in place where there is an identified need for them.
- Ensure that patients with a learning disability receive an annual review.

# The Groves Medical Centre

**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, Practice Manager and an Expert by Experience. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

## Background to The Groves Medical Centre

The Groves Medical Centre is situated in New Malden, Surrey, one of 27 practices within Kingston Clinical Commissioning Group (CCG). The practice has a General Medical Services (GMS) contract for providing general practice services to the local population, and it also provides a number of Locally Commissioned Services (LCS) and Directed Enhanced Services (DES) such as the Childhood Vaccination and Immunisation Scheme and Extended Hours Access. It provides a mix of specialist and complementary health practitioners, a minor surgery unit and a diagnostic centre operated in partnership with a private provider. This service is available to both private and NHS patients. There is also a co-located pharmacy. The website states both the surgery opening hours and the telephone lines are on weekday mornings from 8.30am until 1.00pm, and afternoons from 2.00pm until 6.30pm. Appointments are available during these times. In addition, the practice opens early on Tuesdays and Thursdays at 7.00 am, and is open until 8.00pm on Wednesdays. Outside of these hours patients are advised to contact the out of hours provider.

The Groves Medical Practice is registered with the Care Quality Commission to carry on the regulated activities of Maternity and midwifery services, Diagnostic and screening procedures, Family planning, Surgical procedures, and Treatment of disease, disorder or injury. The Groves has two associate practices situated in Richmond and Wimbledon Park, Surrey. They are registered separately with the CQC and so were not inspected on this occasion.

The practice had recently absorbed two smaller practices which had increased their patient list from approximately 11000 to nearly 16000 and this had had an effect on the capacity of the practice to meet patient demands for appointments. As a result the practice was in the process of obtaining funding to build an additional four consultation rooms, with permission already obtained from the building's owners. They had also increased the number of receptionists to six.

The staff team at the practice were eight male GPs and four female GPs (all a mix of full time and part time hours), a female nurse practitioner, five female practice nurses, four female healthcare assistants; a female phlebotomist and a practice administrative team including a practice manager, a business and operations manager and over 30 reception and administrative staff, including 6 apprentices from the local Council apprenticeship scheme. The senior partner is chair of the Local Medical Committee; whilst another of the practice GPs chairs the local Clinical Commissioning Group (CCG).

The Groves Medical Centre is an approved training practice for GP Registrars and Foundation Year 2 Doctors (a Foundation doctor (FY1 or FY2) is a medical practitioner undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/ general practice training. GP Registrars work for up to twelve months in a practice towards the end of their

specialist general practice training to gain further experience in general practice and take the GP membership examination). It should be noted that a number of these staff are shared between this and the two associate practices.

The practice has a lower percentage (than the national average) of people with a long standing health condition (46.3% compared to 54.0%); and a lower percentage (than the national average) of people with health related problems in daily life (35.2% compared to 48.8%). The average male and female life expectancy for the CCG area was above that of the national average.

The main Black and minority ethnic BME groups in the borough are Indian/British Indian (4%), Sri Lankan (2.5%), African (2.3%) and Korean (2.2%). The Korean population in New Malden is estimated to be the largest in Europe. The Indices of Deprivation rank Kingston upon Thames as the third least deprived local authority in London. The practice has a deprivation score of nine, compared to the national average of 23.6, however the rate of homelessness applications accepted in Kingston for 2013-14 was 3.04 households per 1,000 (which was higher than the England average of 2.32).

The practice has opted out of providing out-of-hours services to its own patients who are directed to a separate provider or advised to contact NHS 111.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. 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?

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, such as policies and procedures, audits, complaints and significant event logs; and asked other organisations such as the CCG, Healthwatch and local nursing and residential homes to share what they knew. We carried out an announced visit on 12 May 2015. During our visit we spoke with a range of staff including doctors, nurses, administrators, receptionists and apprentices, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The practice manager told us that significant events were discussed in meetings and we saw minutes to confirm this. For example we saw one recorded significant event where a patient had been sent a letter asking for them to attend the practice for a vaccination, which had caused the patient considerable distress as due to other health reasons, the vaccination was no longer appropriate. No complaint was made but a significant event analysis was carried out and apologies made. The issue was identified as being caused by incorrect Read coding (Read codes are the standard clinical terminology system used in General Practice in the United Kingdom), and further instructions were sent to all coders.

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

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events, and we were provided with a log dating from May 2014 to the present date, albeit it should be noted that three entries were undated. Recorded in the log was a brief outline of the event and the learning outcomes. For example, one entry related to a repeat prescription being produced for the wrong dosage of medication, and an incorrect vaccine being given during a baby clinic. Whilst, as mentioned, the learning outcome was identified, there was no record to indicate the action that had been taken to reduce the likelihood of the event reoccurring.

Significant events were a standing item on the practice meeting agenda and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The practice has its own proforma for recording significant events and we saw completed forms were stored in a shared network drive.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by email and/or a copy put in the clinical staff pigeon holes. Alerts, clinical queries and protocols were discussed at the weekly clinical meeting and we saw minutes to confirm this. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, for example we saw a recent alert from the The Medicines and Healthcare products Regulatory Agency (MHRA) which had been distributed by email, and related to Medicines related to valproate: risk of abnormal pregnancy outcomes (Valproate is used for controlling certain types of seizures in the treatment of epilepsy in patients who are unable to take the oral form of valproate. It may also be used for other conditions as determined by the doctor). However, we found that not all clinical staff were on the mailing list to receive the alerts, and did not routinely receive copies of minutes.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that almost all staff had received relevant role specific training on safeguarding. Those who had yet to undergo it were three new administrative staff and one GP, who had not yet commenced work at the practice. Nursing staff had completed Level 2child protection training; GPs Level 3 and non-clinical staff Level 1. The practice was aware of recent changes that now required all clinical staff to undergo Level 3 child protection training and was in the process of booking this training. Other than the aforementioned exceptions, all staff had also undergone training in safeguarding adults. Training was repeated on a three yearly basis, and all training was within this timescale.

We asked members of medical, nursing 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 also aware of their responsibilities

and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that the practice learned from incidents. For example a trainee doctor had not consulted with senior colleagues before making a safeguarding referral. This had been reviewed, discussed and procedures amended as a result.

The practice had appointed one GP as the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who this lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example the computer system would flag up to receptionists if a patient with poor mental health wanted an appointment, and patients who required a double appointment were offered one.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Non clinical staff would act as a chaperone if nursing staff were not available. These staff had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Staff who acted as a chaperone had undergone a criminal records check via the Disclosure and Barring Service (DBS).

**Medicines management**

We checked medicines stored in the treatment rooms and medicine refrigerators, of which there were three, and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We saw records that showed staff were recording the temperatures daily, and on the occasion when the higher temperature had slightly exceeded the maximum recommended level the stock had been re-arranged. One of the practice nurses had responsibility for monitoring the temperatures however there were no clear lines of delegation on the occasion the nominated nurse was absent. Staff had continued to carry out the checks, but none had delegated responsibility to do so. We saw that each vaccine refrigerator was equipped with just one thermometer. Good practice guidance recommended two. The practice showed us recently purchased equipment which, once installed, would provide a computerised record of the temperature in each fridge which could be downloaded onto the practice database.

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 in line with waste regulations.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been recently updated. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD. We saw from training plans that two HCA's were due to undergo immunisation update training in August 2015, but were unable to evidence what training they had had to date.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example only three senior partners prescribed for drug dependent patients (of whom there were approximately five). Prescriptions were written on blue prescription pads and medicines prescribed for a maximum of three weeks at any one time. We saw these prescription pads were securely stored. We saw the practice had conducted an audit of patients receiving lithium (used to prevent and treat a number of mood disorders). The initial audit was carried out in April 2014, and a re-audit completed in August 2014. Both audits indicated that all patients prescribed lithium had received a medication and mental health review from the practice, or they were being monitored by the community mental

health team. Blood tests had been carried out at recommended intervals. The practice's performance for antibiotic prescribing was comparable to the CCG average (0.27 compared to 0.38).

All prescriptions were reviewed and signed by a GP before they were given to the patient. The flow of repeat prescription requests was divided up amongst the available clinicians each day by the repeat prescribing administrative team. Some repeat requests were accepted via email and electronic repeat prescriptions were available. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescription pads were not carried in home visit bags.

We noted that action had been taken when there had been some issues with repeat requests. For example some patients had called for prescriptions a day after they had been requested (the practice clearly stated prescriptions would be turned around in 48 hours) but because no record had been made of the day the prescription requests were dropped in, staff were unable to determine if they were overdue or not. In response to this, all requests were now date stamped on receipt.

The practice looked after a number of care homes and had designated staff to deal with their repeat prescriptions. Feedback from the care homes was mixed, with some highly praising the repeat prescription process; others feeling that there was room for improvement but at the same time acknowledging that the practice was doing something about this by allocating specific staff to deal with requests. Records showed that members of staff involved in the repeat prescribing process had received appropriate training.

The practice took part in the prescribing incentive scheme, and funds achieved from that had been reinvested in the practice through the purchase of, for example, new clinical lighting and new flooring.

The practice did not hold stocks of schedule two or three controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

**Cleanliness and infection control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a separate room adjacent to reception where patients with possible infectious illnesses could wait.

The practice had a lead for infection control and we saw from training records that all but one new member of staff had received infection control training. This training was repeated every three years and we saw staff had received training within this timescale. We saw an infection control audit had been carried out in January 2015, however the audit cycle had not yet been completed with a re-audit.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Sharp bins were correctly assembled and dated, and staff disposed of clinical waste appropriately. The practice had lockable wheeled waste bins in the car park and a waste management collection contract in place. Personal protective equipment including disposable gloves was available for staff to use and spillage kits were kept in a locked cupboard in the hallway near reception. Staff were able to describe how they would use these to comply with the practice's infection control policy for example when dealing with samples left in the collection box by patients. Guidance posters relating to hand washing and needle stick injury were on display in treatment rooms for staff to reference.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The last check was carried out in April 2015.

Some of the clinical rooms were carpeted however the practice had acknowledged that this type of floor covering was less suitable than easily washable flooring and was in the process of replacing carpets. At the time of the inspection approximately half of the carpets had been replaced.

**Equipment**

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested

and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date (November 2014 or March 2015). A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer , however we did find one portable blood pressure monitor that had been missed at the last calibration testing day in November 2014. This was brought to the attention of the business manager.

The practice used single use equipment however we found expired needles and syringes in one of the treatment rooms.

GPs were not provided with home visit bags by the practice. Each clinician used their own bag and equipment, and gathered up from the practice whatever additional equipment they felt they may need, including portable devices such as blood pressure monitors. There was no procedure in place to ensure that equipment in the personal bags was regularly calibrated. There was also a lack of clarity regarding emergency medicines as some GPs said medicines, such as Benzyl penicillin, were part of their kit, whilst others said the practice did not provide any.

**Staffing and recruitment**

We reviewed seven staff files which, with the exception of the file of one of the apprentices ( which lacked proof of identification), evidenced that appropriate recruitment checks had been undertaken prior to employment. For example references, qualifications and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy recommended that two references were preferable, but one satisfactory reference would be acceptable, and that a Disclosure and Barring check would be applied for, depending on the position, once a job offer had been made. The practice also maintained a log which listed the information that new employees needed to provide, such as proof of identification, a recent photograph and an employment history.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual assessments of, for example, fire safety (last carried out in November 2014) and first aid (April 2015), however although we were informed that regular health and safety checks were carried out of the building and the environment, these were not recorded. 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 lead.

We saw that any risks and health and safety were standing agenda items at clinical and non-clinical staff meetings. There had not been any issued raised in the minutes we reviewed of meetings in April 2015.

The software used by the practice provided an on-screen panic button on all computer screens in case of emergency however this facility was not available on the computer screen we checked in one of the GP consulting rooms. Staff had not noticed it was not being displayed and were unaware of the reason why this may be case.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example the practice monitored repeat prescribing for people receiving medication for mental ill-health, and where appropriate these were written on blue prescription pads and for a maximum of three weeks at one time.

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

The practice had arrangements in place to manage emergencies. Records showed that all staff apart from the newest team members (recruited within the last two months) had received training in basic life support. This was repeated on a three yearly basis, and not annually as recommended in the UK resuscitation council guidelines.

Requires improvement

# Are services safe?

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of the aforementioned equipment and records confirmed that it was checked regularly. The practice also had two nebulisers, however not all clinical staff knew of their whereabouts.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (severe allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. There was a list of medicines and their expiry dates on display on the inside of the cupboard where they were stored. All the medicines we checked were in date and fit for use. We found that whilst the practice had appropriate emergency equipment and medicines, these were kept in separate places around the building. For example, oxygen masks were kept in a different location to the oxygen cylinder; the defibrillator and oxygen were in main reception whilst emergency medicines were kept in a locked cupboard in the main corridor, the keys to which were kept in another cupboard in one of the nurse's rooms, for which a code was needed. Not all staff were aware of the location of the keys to the emergency medicines cupboard. Anaphylaxis kits were only available in the nursing rooms therefore any urgent use of these would mean interruption to ongoing clinical care in the nursing rooms. One of these kits was checked and we found appropriate medicines and syringes but no needles for their delivery.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This was last updated in April 2015. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included natural disaster such as a flood or storm damage; environmental issues such as an aircraft crash or building collapse; civil disturbance; theft; terrorism; technology failure or a medical emergency. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in November 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Responsibility for weekly fire alarm checks lay with the adjoining diagnostic centre, however staff confirmed that they heard the alarms being tested every week. Staff at the Groves checked the emergency lighting weekly and we saw records that confirmed this. Fire extinguishers had recently (May 2015) been replaced throughout the practice.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. However there were no structured meetings where clinical staff could discuss NICE or similar guidelines. We were told these may be discussed at the weekly clinical staff meeting on an ad hoc basis and on occasion external speakers were asked to attend. Since February 2015 the CCG had introduced protected learning time once every three months and clinical staff we spoke with confirmed they were able to attend training courses and maintain their continuous professional development.

The practice had 135 patients on its mental health register of whom 82 had been coded as having a comprehensive care plan. We randomly selected two of these patients' records to review. We found that both contained care plans, which had been drafted by the community mental health team (CMHT), without GP involvement. One patient was prescribed antipsychotic medication (administered by the CMHT) but they had not had a physical check up from the GP for over two years and there was nothing on their record to alert staff to possible side effects of their medication. The second record we reviewed also contained a care plan drafted by the CMHT, with no GP input. This record stated the patient had had their blood pressure checked within the last year and their medication reviewed but no other details had been entered on the record to indicate, for example, that discussion had been held with the patient regarding their medication, compliance or if they had had a recent full physical check-up or blood tests. We were told that although selected randomly, both these records were of patients 'inherited' from a practice the Groves had taken over within the last year.

The practice had signed up to the Avoiding Unplanned Admissions (AUA) for High Risk patient group enhanced service (ES) (this ES is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. Practices are required to have care plans in place for this identified group). It was a little problematic to obtain a list of AUA patients as the member of staff who usually dealt with this was on leave and there did not appear to be a specific re-allocation of work when staff were absent and the GPs did not have direct access to a list. We did however manage to obtain a list and randomly selected for review two care records for patients who fell under this criteria. The first record contained patient information and carer details however the accuracy of information in the care plan relating to health problems was poor. For example, one particular physical health problem was mentioned however there was no mention of a more pressing mental health problem and on-going frequent input from the CMHT.

The second record we reviewed had more accurate information. Mention was made in the care plan of a 'do not attempt resuscitation record' although there was nothing to indicate what discussions had been held with the patient or possibly family members and no review date.

Data showed that the practice was slightly above the CCG averages for referral rates to secondary and other community care services for most conditions. All GPs we spoke with used national standards for the referral of, for example, patients with suspected cancers who were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. Referrals, except two week urgent ones, were all screened first by a partner GP before sending via Choose and Book. Two week referrals were directly sent on the day.

We were told that there had been problems historically with faxing two week wait referrals with faxes going astray. As a result the practice now sent referrals via emails and a received/read receipt was requested.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child

protection alerts and medicines management however there was no apparent system in place for designated staff to cover specific tasks for colleagues if those colleagues were, for example, on leave.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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 practice achieved 895 points out of a total of 900 for the year 2013/14 (four percentage points above CCG Average and six above England Average).

The practice told us they had carried out a number of audits including audits relating to Infection control (January 2015), Cytology (November 2014), Ezetimibe (a drug that lowers plasma cholesterol levels, in January 2015), Asthma and Diabetes. We reviewed completed audits for asthma and diabetes. The initial asthma audit had been carried out in July 2014, and a re-audit had taken place in February 2015. The initial audit had indicated that, 70% of patients had a personalised action plan as part of self-management education; 72% had been reviewed at least annually and long-acting beta2-agonist (LABA) dosage was reduced or stopped in 42% of stable patients when reviewed or if the patient had had no response to LABA. The re-audit had shown patient outcomes had improved, with percentages rising to 75%, 82% and 44% respectively. In addition four patients had stepped down from LABA treatment.

The diabetes audit related to the prescribing of newer hypoglycaemics. The initial audit was completed in November 2014 and reviewed 27 patients; with a re-audit in March 2015 of 40 patients. The findings resulted in a number of patient medicine reviews, and led to four medicine changes and three cases where medicines were stopped.

The practice was registered with the CQC to perform minor surgery. One specific, salaried GP undertook these procedures. We requested copies of consenting policies, performance audits and any relevant significant events or complaints relating to minor surgical procedures. However with the exception of a consent policy, which did not specifically refer to consent for minor surgery, the practice was unable to provide information as the GP was unavailable and the nurse who specifically dealt with this area was on leave. Post the inspection we were provided with an audit carried out in January 2014 to assess infection rates arising from minor surgery carried out at the practice. The audit indicated a 1% infection rate. A re-audit had not been completed.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example the practice met all the minimum standards for QOF in atrial fibrillation, chronic kidney disease, dementia, depression, epilepsy and heart failure. It achieved most of the standards for asthma (achieving 44.9 out of 45 points), diabetes (106 out of 107 points) and chronic obstructive pulmonary disease (COPD) with 34 out of 35 points. This practice was an outlier in relation to emergency coronary heart disease (CHD) admissions with 14.34% compared to the national average of 7.95%. Kingston CCG reports showed that whilst the practice, since March 2010, had been consistently above the CCG area average for this type of admission, its performance had steadily improved over time. The most recent data, for March 2015, showed that the practice now matched the CCG average.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had acknowledged that in quarter two of 2014 it had had an elevated risk associated with its dementia diagnosis rate, which had stood at 18.8% compared to a national average of 54%. We were told that this had been reviewed, action taken to increase the number of patients offered a cognitive review, and the current performance now stood at 59.6% (we were unable to confirm this via the

Good

# Are services effective?

## (for example, treatment is effective)

QOF database as the figures were not available. We confirmed through the GPOS data (NHS England general practice outcome data) however that the practice had improved to 50.76% by the end of quarter three 2014).

The practice also participated to a degree in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example the local CCG provided a lot of data and feedback to local practices and a CCG wide intranet webpage network incorporating this feedback and a lot of other aspects such as CCG wide policies was in place. However, within this practice this appeared to be in a pilot phase as only the senior partners and managers were aware of it. We reviewed a CCG report from November 2014 which looked at A&E attendances. Some of this data was being perused further in detail by senior partners but wider shared learning was not in place.

**Effective staffing**

The practice was in the process of recruiting a clinical pharmacist (a clinical pharmacist work directly with doctors, other health professionals, and patients to ensure that the medications prescribed for patients contribute to the best possible health outcomes). A number of the GPs had special interests in, for example, drugs and alcohol, sexual health, the elderly, diabetes, mental health and baby clinics. There was a six member nursing team of whom one was an independent nurse prescriber, and other nurses had specific long term condition clinical interests.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support, fire safety, health and safety, infection control and safeguarding. The GPs we spoke with told us they were up to date with their yearly continuing professional development requirements and had either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff who had been in post for at least a year received an appraisal that identified future learning needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example some of the receptionists had undergone phlebotomy training. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and phlebotomy. Those with extended roles, for example those who saw patients with long-term conditions such as asthma, COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

**Working with colleagues and other services**

We spoke with four of the nursing and residential homes who receive a GP service from this practice. Generally their comments were positive. We were told that the GP(s) visited regularly, and responded well when asked to visit outside of their regular visiting days. The doctors also made appropriate referrals, usually returned calls, and the homes appreciated having the same doctor attending for the regular weekly or fortnightly clinics. Some less positive comments were received regarding the difficulty in sometimes getting through to a GP by phone, as calls were screened by the receptionists and initially passed to one of the practice nurses. One home told us the inability to speak to a GP had resulted in several patients being transferred to the local A&E department, which potentially could have been avoided. Some criticism was also made of the quality of GP notes, which we were told often only said 'visited' and did not provide a summary.

There were mixed comments from the residential and nursing homes regarding the repeat prescription service, ranging from outstanding to not working well. Those not totally happy with the service commented that this was because of the length of time it took for the practice to send them through, sometimes waiting over a week post GP visit. If dosages were altered, this was not being communicated to the home (either verbally or in the patient notes) so when an amended prescription arrived

time had to be spent contacting the practice to confirm the change. All the homes we spoke with however were complimentary about the helpfulness, caring attitude and responsiveness of the GPs themselves.

The GPs used a dictation system for referral letters and prioritised them depending on the urgency. Administrative staff then typed the letters and logged each one before sending. All those falling under the two week wait rule were emailed and a delivery receipt requested. Choose and Book referrals were also logged before being faxed to the local Kingston referral service(Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Confirmation of receipt of the fax was requested and staff kept these for a six month period in case there were any future queries.

The practice worked with other care professionals, such as the district nurses, community matrons and rapid response team to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. These were then scanned into patient records. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team monthly. We were told by the GPs that these meetings were attended by, for example, district nurses, palliative care nurses and health visitors. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 554 referrals in the first three months of 2015 through the Choose and Book system. The practice had trained one person specifically to utilise the choose and book system however they had recognised that if this person was absent there could potentially be a delay for patients so another member of staff was undergoing training in the system.

The practice had signed up to the electronic Summary Care Record system. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). We were told patients were offered the choice to opt out if they did not want their records shared in this way.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record – Vision (but were scheduled to change to EMIS-Web in the forthcoming months) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

We were told that all clinical letters were read by clinicians. These were distributed in folders by reception on a daily basis to available clinicians. Actions were taken by clinicians or communicated back to reception to action in person. The letters were stamped with the date and signature of the clinician with action taken and any read codes highlighted to be added. However there was no audit trail to confirm if this worked well.

The practice had a central pool for test results, which were distributed by admin staff to available clinicians. One of the senior partners and also the nurse practitioner were responsible for allocating any results in the pool that had not been sent to individual GP email inboxes, with the aim of actioning all results on a daily basis. The GP inbox we checked contained just one pending result. Urgent results were telephoned through by the testing laboratory. If this happened to be when the practice was closed, the out of hour's provider was contacted instead. We were shown where this had worked well in practice as a concerning result for a child (with raised serum potassium levels) had been telephoned through to the out of hours team who had in turn contacted the child's parents and had an urgent repeat test carried out.

**Consent to care and treatment**

Good

# Are services effective?

## (for example, treatment is effective)

We found that clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. One of the GPs was able to give us an example where they had been involved in a dispute between two family members about the care of their elderly relative who lacked capacity and was resident in a care home. The practice had referred the issue to the local adult safeguarding team.

Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).The practice had a consent policy which set out its approach to gaining consent. The policy outlined the difference between implied and expressed consent, and also provided guidelines for staff with regard to Gillick competency. The policy did not make any specific reference to minor surgical procedures, which the practice was enabled to do as part of its registration conditions. We requested sight of any audits relating to consent – for example an audit that confirmed the consent process for minor surgery had being followed, however these had not been performed.

**Health promotion and prevention**

One of the practice GPs, in their role as chair of the CCG, had met with the Public Health team from the local authority and colleagues from the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Patients could book an appointment for this through the practice website. Practice data showed that 5187 patients were eligible, 3367 (64.9%) were offered a check and of these 2184 (42%) took up the offer. These checks had led to 26 new diagnoses of diabetes; four of chronic kidney disease and 80 of hypertension.

The practice had ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability. Practice records showed four out of 21 had received a check up in the last 12 months. The practice had also identified it had 1518 patients who smoked and actively offered smoking cessation advice to 96.9% of these patients. The number of patients who had stopped smoking in the last 12 months was 12. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese for example. The practice did not run its own obesity clinics however patients who attend for free NHS health check were appropriately directed to a local weight management clinic where they could make their own appointments.

Home visits were available. Requests for these were triaged by one of the GP partners and, we were told, distributed to GPs based on continuity, appropriateness or to ensure parity of visits amongst doctors. We saw all home visits requested and completed were logged by reception staff.

The practice provided care for residents in eight nursing/residential care homes with five being exclusively registered with the surgery. The practice offered routine weekly visits/rounds for some of these homes and acute visits as needed. Patients aged over 75 had a named GP and the practice had signed up to the avoiding unplanned admissions-enhanced service. The patients on this register were offered monthly calls.

The practice maintained a register for each long term condition, and also for its patients with a mental health illness. We were told that the practice invited patients on these registers in for an annual health review. Records provided by the practice indicated that, for example, over the course of the past year the practice had reviewed 67% of its asthma patients; 85% of its patients with diabetes and 80% of its patients with a mental illness. Some of the nursing team had specific interest and training in long term conditions, and provided, for example, a diabetes clinic which offered in-house insulin initiation. The practice provided a named GP for any patient newly diagnosed with cancer.

Good

# Are services effective?

## (for example, treatment is effective)

The practice's performance for cervical smear uptake in the preceding year was 76.6%, which was slightly below the CCG average of 77.52%. The practice felt that this was partly due to its merger with another practice which had affected their figures. There was a policy to offer reminders for patients who did not attend for cervical smears. The Breast Cancer Screening Programme has a three yearly recall for practices, and patients from the Groves had recently been invited. At the time of this inspection 1530 had been invited for screening and 602 had so far attended.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was above average for the CCG, for example 94.1% of children aged 24 months had received an MMR vaccination compared to the CCG average of 89.2%; 92.7% of 5 year old children had received the Dtap/IPV Booster compared to the CCG average of 83.1%. However the practice fell below the CCG average for seasonal flu vaccinations for patients aged over 65 (65.45% compared to 73.24%) and for patients aged over 6 months to under 65 years in the defined influenza clinical risk groups achieving 39.9% compared to the CCG average of 52.29%. The practice commented that they needed to improve their recording of patients who were offered but declined a vaccination, so that this dissent could be included in the practice achievement figures.

The practice also offered a baby clinic, at which a health visitor was available to give advice; clinics for maternity, minor surgery, family planning – which included a sexual health service and the fitting of coils and implants; occupational health and travel. Patients were able to access a range of information via the practice website. This included videos showing how to use an inhaler and a glucometer; explanations of procedures such as a spirometry test and guidance on long term conditions such as asthma, heart disease, diabetes; epilepsy, hypertension and respiratory disease. The website provided links to organisations such as the British Lung Foundation. There was also guidance on healthy living, which included specific sections on alcohol, weight control, healthy eating, sexual health, smoking and keeping fit.

The practice supported its students and working age patients by offering extended opening hours, telephone appointments, online bookings and temporary registration for university students.

Data from QOF indicated the practice exceeded the national average for having a comprehensive care plan in place for patients with schizophrenia, bipolar affective disorder and other psychoses achieving 96% compared to the national average of 86%. It also exceeded the national average for the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months, achieving 93% compared to the national average of 84%. The practice had last year been identified as an outlier for its dementia diagnosis rate, achieving just under 19% compared to the national average of 54%.The practice had acknowledged this and taken steps to improve. At the time of the inspection we were told the rate had increased to 59.9%.The computer system would flag up to receptionists if a patient with a mental health illness wanted an appointment, and patients who required a double appointment were offered one.

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 GP patient survey 2014, CQC comment cards and the most recent results of the Friends and Family Test (a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses). Up until 2014, the practice had also conducted an annual patient satisfaction survey through its Patient Reference Group, but had decided going forward to only use the Friends and Family Test (FFT). The evidence from all these sources showed patients were not wholly satisfied with how they were treated. For example, data from the national patient survey showed the proportion of respondents who described the overall experience of the GP surgery as fairly good or very good was 82%, compared to a national average of 86%.They were in keeping with the CCG average of 83% however.

Seventy two percent of patients who responded said that the last time they saw or spoke to a nurse, the nurse was good or very good at listening, which was below the national average of 79%, and the CCG average of 78%. Eighty percent of those patients who commented on the last time they saw or spoke to a GP said the GP was good or very good at treating them with care and concern. This was the same as the CCG average, and compared favourably to the national average of 82%. Similarly, the practice achieved the same positive response for the GP listening as the CCG (86%) which was just below the national average of 88%. The practice was below the CCG and national average for patient satisfaction with the time given by the GP (75% compared to the CCG (82%) and national (86%) average) and the nurse (77% compared to 79% and 81% respectively).

In contrast to the national GP patient survey, results from the FFT covering December 2014 – January 2015; and February - April 2015 indicated that the majority of patients who responded were satisfied with the service they received. There was a range of Information leaflets in reception to help patients understand the services available.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 37 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Seven comments were less positive and revolved around one common theme – difficulty in getting appointments. We also spoke with five patients on the day of our inspection, and two members of the Patient Reference Group. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to suggestions from the Patient Reference Group, a notice had been displayed asking patients to queue away from the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. People whose circumstances may make them vulnerable were able to access the practice without fear of stigma. For example, patients with poor mental health were offered appointments at less busy times to reduce stress levels. The computer system would flag up to receptionists if a patient with a mental health illness wanted an appointment, and patients who required a double appointment were offered one.

Good

# Are services caring?

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey 2015 showed 76% of practice respondents said the GP involved them in care decisions and 80% felt the GP was good at explaining treatment and results. Both these results were above the CCG average of 70% (national average74%) and 79% (national average 82%). The practice achieved comparative responses to the CCG in relation to how the nurse involved them in their care, as 60% (CCG average 61%) said the nurse was good or very good, but this was below the national average of 67%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patient feedback on the comment cards we received was also aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. Sometimes patients would bring a family member with them to translate, however if this was a child the GPs told us they would use a translation service instead.

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

None of the patients we spoke with on the day of our inspection or who completed the CQC comment cards mentioned emotional support or treatment however notices in the patient waiting room and on the practice website told patients how to access a number of support groups and organisations. We saw the practice had a bereavement information leaflet for patients, which offered guidance on what to do if there was a bereavement at home, and advised patients the practice could offer counselling following the death of a loved one.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

We were informed that there was close liaison between the practice and the CCG – particularly as the chair of the CCG was one of the practice partners, however there was no documented evidence to support this or indicate how discussions with the CCG had led the practice to implement service improvements or manage delivery challenges to its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PRG). For example, the need to review and improve the availability of appointments had been identified by the PRG in 2012, and as a result the practice increased both its GP and practice nurse complement. It had also introduced telephone consultations to ease the burden on the demand for face to face consultation. The success of this had been reviewed each year, however the practice had recently acknowledged that it still required additional capacity and had submitted a funding bid to the Primary Care Infrastructure Fund. More recently, as outlined in the PRG meeting minutes for March 2015, the PRG had identified that confidentiality at the reception desk was compromised. The practice had displayed a clear notice asking patients to queue away from the desk and also advertised that patients could speak with staff in confidence in an adjoining room. It was noted that there was a letterbox for the patient reference group to drop comments however it was sealed, making it more difficult for feedback to be given.

We spoke with two members of the PRG during the inspection. Their feedback was in the main positive, particularly with regard to the service they felt people with disabilities received, and the practice's decision to have as one of its priorities Alzheimer and dementia care, however less positive comments were also made regarding the lack of clear terms of reference for the group; the need for the group to be patient not practice led, and on-going criticism of the appointment system.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example, it provided services for patients with a drug or alcohol dependency, and patients with no fixed abode. The practice had a majority population of English speaking patients though it could cater for other different languages through translation services. Longer appointments were available for people who may need them, for example those experiencing poor mental health, and staff told us they tried to avoid booking appointments for these patients at busy times, as they may find this more stressful.

The premises were purpose built in 2005 and were adapted to meet the needs of patient with disabilities, including five disabled parking spaces, ramp access and automatic external doors. The practice was situated on the ground and first floors of the building with services for NHS patients predominantly but not exclusively on the ground floor. There was lift access to the first floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities.

**Access to the service**

Comprehensive information was available to patients about appointments on the practice website, albeit some of this was not up to date. We raised this with the practice and were told that the website was managed by an external company, and the terms of the contract only allowed periodical updating. Information on the website included how to arrange urgent appointments and home visits. The practice offered online booking through a separate web based application however this facility was not promoted on the practice website.

The website stated both the surgery opening hours and the opening of telephone lines were on weekday mornings from 8.30am until 1.00pm, and afternoons from 2.00pm until 6.30pm. Appointments were available during these

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

times. The morning opening hours were half an hour less than was the norm nationally. We were told this was a CCG wide decision, however could not confirm this via the CCG website as advertised opening times of other practices within the CCG area varied.

In addition, the practice opened early on Tuesdays and Thursdays at 7.00 am, and was open until 8.00pm on Wednesdays. Post inspection we were informed that the practice also opened at 7.00 am on Mondays (this information was not on the website).These extended opening hours were for pre-booked appointments only, and patients who had appointments within these times were advised to ring the doorbell to be let into the building. Outside of these times, patients were asked to telephone the normal appointment number, and they would be directed to the out of hour's service contracted by the practice. The website also advised patients they could contact NHS 111 for advice. Appointments could be booked up to four weeks in advance.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to five local care homes on a specific day each week, and additionally to those patients who needed, one by a named GP.

Information from the national patients survey 2015 showed patient satisfaction with the appointment system fell below that of the CCG and nationally. For example, 60% responded positively to the ease of getting through on the phone, compared to 64% in the CCG and 71% nationally. Sixty four percent said they were able to get an appointment when they wanted one (CCG 68%, national 73%) whilst 84% were satisfied with the convenience of the appointment compared to 90% in the CCG and 92% nationally.

The proportion of respondents to the GP patient survey who stated that they always or almost always saw or spoke to the GP they preferred was 23%, compared to a CCG average of 32% and a national average 37%. Sixty two percent commented favourably on the experience of making an appointment compared to 68% in the CCG and 73% nationally, however these outcomes notwithstanding, the number of patients who rated their overall experience of the practice as good or very good was 82%, which was just below the CCG average of 83% (national average 86%).

Feedback from patients we spoke with, the patient reference group members and comments on the CQC comment cards confirmed the aforementioned dissatisfaction findings of the national patient survey. Whilst patients confirmed that they could see a doctor on the same day if they needed to, we witnessed long queues of patients when the practice opened in the morning as they felt they had to call in person to get an appointment, and some of those we spoke with were unaware they could call in the morning for an afternoon consultation. There was also dissatisfaction with the advance appointment booking system, with some patients commenting they had to wait weeks before one was available. We reviewed the pre-bookable system and found the next available routine appointment, with any GP, was 15 days away.

The practice's extended opening hours on Tuesday and Thursday mornings and Wednesday evenings was particularly useful to patients with work commitments however feedback from patients indicated that this facility was not widely known.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. Complaints were discussed in the regular staff meetings and staff we spoke with were able to outline what to do if a complaint was made to them. Staff told us that wherever possible they tried to de-escalate problems and deal with concerns immediately

The practice provided us with a copy of its complaints log for 2014 and 2015. The 2014 log indicated that there had been 41 logged written complaints. The majority of these related to the appointment system. The practice felt that this was largely due to the merger of this practice with another which had increased the list size by over 4000. In some instances the practice had noted in the log that there was a service delivery failure which could be addressed – however it did not always state how this would be achieved or if it had been achieved. The 2015 log contained 13 written complaints to date. More than half of these related to the appointment system. The partners were aware of this issue. One senior partner stated that they kept half of all appointments for on the day access, which explained the queue outside when the inspection team arrived. They

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

had existing vacancies for GPs and recruitment has been an issue however two of the registrars were joining the team as GPs in the near future. They had also embarked on seeking funding and planning permission to build an additional four consulting rooms.

The practice had a complaints leaflet although patients had to ask for one as none were on display in the reception area. Additionally we noted that the complaints procedure was not available on the practice's website. Patients could complete a feedback form online, but there was no reference at all to making a complaint. Friends and Family Test questionnaires were clearly on display in reception, and there was a box available for patients to drop in completed questionnaires. None of the patients we spoke with had had the need to raise a complaint.

We noted that the patient reference group (PRG) post box in reception was sealed, which did not facilitate feedback. We were informed post inspection that this was no longer in use and an alternative post box was provided. Members of the PRG did confirm however that the practice provided feedback to them with regard to the number of complaints and the issues being raised.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. These values included providing high quality care for the patient population; providing a facility to meet the needs of the patients; to integrate with the community and to be a leading practice with innovative ideas.

We spoke with 14 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The practice had recently absorbed two smaller practices which had increased their patient list from approximately 11000 to nearly 16000 and this had had an effect on the capacity of the practice to meet patient demands for appointments. As a result the practice was in the process of obtaining funding to build an additional four consultation rooms, with permission already obtained from the building's owners. They had also increased the number of receptionists to six.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice, and also hard copy. We found it was not always easy to navigate the shared drive. For example, some of the GPs were unable to locate the practice's policy on antibioticprescribing. We looked at a number of these policies and procedures, including those relating to, health and safety, fire safety, portable appliance testing, infection control and repeat prescribing. All the policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control; a designated member of staff to lead on QOF; the practice manager led on complaints; one of the partners led on information governance and was the designated Caldicott Guardian (A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information) and the senior partner was the lead for safeguarding. We spoke with 14 members of staff and whilst they were all clear about their own roles and responsibilities not all knew who the various leads were. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. They also felt there were involved in decision making where appropriate. Weekly partnership meetings were held, but were not minuted.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards and had achieved 895 points out of a total of 900 for the year 2014.The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We reviewed examples of completed audits regarding lithium prescribing, asthma and diabetes.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw completed risk assessments in relation to fire safety and first aid however whilst we were told regular health and safety checks were carried out of the building and the environment, these were not recorded. Risks and health and safety were standing agenda items at clinical and non-clinical staff meetings. There had not been any issued raised in the minutes we reviewed of meetings in April 2015.

The practice maintained a log of significant events however not all GPs were aware of this. Similarly, not all GPs were aware of the business continuity plan. Weekly partnership meetings were held but not minuted which meant there was no audit trail to refer to for, for example, decisions made, actions to be taken and accountability for those actions.

**Leadership, openness and transparency**

We saw from minutes that there was a weekly clinical meeting for all clinical staff including the health care assistants. There was a standard meeting agenda for this meeting which included, for example, complaints, safety alerts, health and safety and significant events. Reception/ administrative meetings were held twice monthly. We saw minutes from one meeting where, for example, safeguarding, staff training and health and safety had been discussed. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

# Are services well-led?

Good

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example re recruitment, whistleblowing and confidentiality were in place to support staff. Staff were also provided with a handbook which contained information relating to, for example, disciplinary procedures, capability procedures and the grievance procedure. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the Friends and Family Test and complaints received. They also received feedback from their Patient Reference Group (PRG). The PRG met two to three times annually, and consisted of 10 members, four male and six female. The practice acknowledged the group was not representative of its patient list but that it proved difficult to increase both the membership and diversity. Patients were asked if they were interested on an ad hoc basis when attending for an appointment and there was information on display in the reception area. Information was also provided on the practice website, including previous annual reports. A common theme emerging from feedback related to the difficulty patients reported in telephone access and advanced appointments. The practice had taken action to address this however these remained ongoing issues and the practice continued to look at ways to improve the situation.

Data from the national patient survey showed the proportion of respondents who described the overall experience of the GP surgery as fairly good or very good was 81.52%, compared to the CCG average of 83% and the national average of 85.76%. However the practice was above the CCG average, and slightly above the national average, for the number of patients who would recommend the practice to others achieving 79% compared to 76% and 78% respectively.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

**Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at seven staff files and saw that where staff had been in post for a year or more, they had had an annual appraisal and a performance development plan. Staff told us that the practice was very supportive of training and open to constructive criticism.

The practice had been a GP training practice for the past 16 years. Two of the GPs were trainers and supervisors for the registrars and foundation 2 doctors who were placed at the practice. Medical students from four local hospitals were also provided with placements.

The practice also provided placements for apprentices from the local college, and where possible and provided the apprentice was suitable, permanent offers of employment were made. We spoke with a number of apprentices all of whom were very positive about their experience and the support they received.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Discussion of significant events and their outcome was a standing item on the agenda of the practice meetings however whilst learning outcomes were identified, there was no record to indicate the action that had been taken to reduce the likelihood of the event reoccurring. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

A number of staff at the practice had roles within the wider community setting, for example the Mayoral transformation board; the medicines management committee; the local CCG; the local LMC and the practice managers group. Staff felt that this enabled them to keep abreast of current practice and new developments, and provided a forum to share ideas.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>How the regulation was not being met: the registered person had not ensured that all equipment was in date; that all relevant staff knew where to find emergency equipment; or that health and safety risk assessments were carried out and recorded. Regulation 12 (1) (a) (d) (e) |