# Dr Jedrzejewski and partners

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

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

We carried out an announced comprehensive inspection at Dr Jedrzejewski and partners on 28 July 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing, effective, caring and responsive services. It required improvement for providing safe and well led services. The concerns that led to the practice requiring improvement for providing safe and well-led services applied to all the population groups. Therefore the practice requires improvement for the care of older people, people with long term conditions, for providing services to families, children and young people, working-age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Most staff understood and fulfilled their responsibilities to raise concerns, however some reporting of incidents and near misses did not take place. Evidence of learning from incidents was limited.
- Risks to individual patients were assessed and well managed but there was no systematic approach to clinical governance within the practice.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- In some areas staff had received training appropriate to their roles. The practice had identified other areas where training had not been kept current and was addressing this.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

# Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. Evidence of governance was limited as was evidence of communication across the practice. There were departmental meetings but no forum or other mechanism to share learning and direction across the whole practice.

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

Importantly the provider must:

- Ensure a systematic approach to reporting, recording and monitoring significant events, incidents and accidents.
- Ensure there are formal governance arrangements in place and staff are aware how these operate, including maintaining the cleanliness and fabric of the building.

In addition the provider should:

- Review staff training to link this to personal development plans and practice's needs.
- Review staff files to ensure that all contain the required information

**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. Most staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However not all administrative staff understood when to raise concerns. When things went wrong lessons learned were not communicated widely enough to secure improvements. Risks to patients were assessed and there were systems and processes to address these risks, however risks to the practice as whole were not systematically addressed.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services. Data showed patient outcomes, in most areas, were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it, and other best practice, routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation, this included promoting good health. Most staff had received training appropriate to their roles. There was evidence that appraisals were planned for staff and that consideration was given to their personal development though the staff records did not always reflect this.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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 NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. It acknowledged the needs of its substantial Nepalese community and took positive steps to try and ensure they were addressed. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments

# Summary of findings

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

**Are services well-led?**

**Requires improvement**

The practice is rated as requires improvement for being well-led. It had a vision and a strategy and staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and these were fit for purpose. The governance structures were fragmented with staff's learning and direction limited to the department they were in. There were departmental meetings but the findings were not shared. There were audits to monitor and assess patient outcomes. The practice had systems to seek and act upon feedback from patients.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Requires improvement

The practice is rated as requires improvement for the care of older people because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example home visits elderly house bound patients and there was a nurse trained and designated to the care of the over 75s. The practice had a designated named GP for patients who are 75. There were care plans where appropriate for older patients. Longer appointments and home visits were available for older people when needed. The rate of influenza vaccination for patients over 65 years was better than the national average.

**People with long term conditions**

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. Nursing staff had lead roles in chronic disease management. Longer appointments and home visits were available when needed. These patients had as a minimum a structured annual review to check that their health and medication needs were being met. There were services, such as spirometry, 24 hour blood pressure monitoring, electro-cardio grams, for those with long term conditions.

**Families, children and young people**

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. However there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who were the subject of child protection plans. The practice's performance for child immunisations was very good, outperforming the nationally achieved results, often significantly so.

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

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students) because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this

# Summary of findings

population group. The needs of this group had been identified and the practice had adjusted the services it offered to help to ensure these were accessible, flexible and offered continuity of care. For example the practice offered late evening appointments twice a week. There were telephone consultations were appropriate instead of patients attending the practice. The practice offered online prescription ordering and online appointment services. The practice offered a full range of health promotion and screening that reflected the needs of this group.

**People whose circumstances may make them vulnerable**

**Requires improvement**

The practice is rated as requires improvement for the care of patients whose circumstances may make them vulnerable because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for all its patients with a learning disability. It offered longer appointments for patients with a learning disability.

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

**Requires improvement**

The practice is rated as requires improvement for the care of patients experiencing poor mental health (including patients with dementia) because the concerns that led to the practice requiring improvement for providing safe and well led services applied to this population group. The practice informed patients experiencing poor mental health about how to access support groups and voluntary organisations. Historically the practice's diagnosis of patients with mental illness had been well below what was to be expected. The practice had recognised this and had markedly improved their performance in this area.

# Summary of findings

## What people who use the service say

As part of our inspection process, we asked patients to complete comment cards prior to our inspection. We received two comment cards and spoke with four members of the Patient Participation Group (PPG). All comments received indicated that patients found the staff helpful, caring and polite and all described their care as very good.

For the practice, our findings were in line with results received from the National GP Patient Survey. For example, the national GP patient survey results for 2013/14 showed that 79% of patients would recommend the practice to other people, 96% said they were able to get a convenient appointment and 91% said that their GP was good at listening to them. All results are significantly higher than the national average.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure a systematic approach to reporting, recording and monitoring significant events, incidents and accidents.
- Ensure there are formal governance arrangements in place and staff are aware how these operate, including maintaining the cleanliness and fabric of the building.

**Action the service SHOULD take to improve**

- Review staff training to link this to personal development plans and practice's needs.
- Review staff files to ensure that all contain the required information

# Dr Jedrzejewski and partners

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC inspector and included a GP specialist advisor and a practice manager specialist advisor.

## Background to Dr Jedrzejewski and partners

Dr Jedrzejewski and partners is a GP practice in an urban area of Folkestone. The demographics of the practice population are very similar to the national average, with the exception that about a fifth of the practice's patients are of Nepalese origin. This arises from the areas traditional links with the Ghurkha servicemen who are barracked nearby.

The practice has approximately 9600 patients. There are three partner GPs and one salaried GPs and the practice employs regular locum GPs. The practice employs seven nurses and a healthcare assistant. The practice is open 8.30 am – 6.30 pm Monday to Friday. There are extended surgery hours until 8.15pm on Mondays and Tuesdays.

Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service that is provided by Integrated Care 24 (IC24). The number of this service is clearly displayed in the reception area and on the practice website. The practice has a PMS (Personal Medical Services) contract and also offers enhanced services for example, various immunisation and learning disabilities health check schemes.

## 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

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 28

# Detailed findings

July 2015. During our visit we spoke with a range of staff including a GP partner, nursing staff, receptionists and administrators. We spoke with patients who used the service.

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

Requires improvement

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risk and improve quality regarding patient safety. For example they considered reported incidents and accidents, national patient safety alerts as well as comments and complaints received. The practice had a significant event monitoring policy and most, but not all staff were aware of the need to record and report events. Not all areas of the practice were reporting events. We were told of events, such as administrative errors in the patients' records which, whilst they were resolved without detriment to the patient, were not recorded. The practice had a significant event recording form but it was underutilised by staff so there was no common understanding by staff of what should be reported and how it should be processed.

### Learning and improvement from safety incidents

Significant events were discussed at the partners' regular weekly meeting. It was apparent from the meeting minutes that this was an open practice that encouraged reporting of events. The practice took professional advice, for example from the Medical Protection Society (MPS) where necessary. Meeting minutes showed that there had been learning from the events. The learning was shared amongst GPs, nurses and the practice manager but there was no evidence that other staff were involved in the learning. There was no log of significant events so the practice could not identify, through analysis, whether there were any themes or trends in events which could be addressed by actions such as staff training or changes to processes.

There was a process for dealing with safety alerts. These were received by the practice manager and passed to the GPs and nurses when the alerts were relevant. Records showed that one recent alert which concerned medicines had been received at the practice. The patients who were affected were identified and the instructions in the alert followed.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records showed that all the GPs and nurses had received relevant role specific training on safeguarding. Some staff we spoke with told us they had received safeguarding training but the practice records were incomplete in this respect.

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were aware of their responsibilities under the policy. The practice had a dedicated GP for safeguarding vulnerable adults and children who had undertaken the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead for safeguarding was and who to speak to in the practice. We discussed some safeguarding cases that the practice had raised and were satisfied that the cases had been raised and discussed following the correct procedures.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The practice nurses had been trained as chaperones. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. Temperatures were checked and recorded manually as well as by electronic control devices. There was a stock control process to ensure that 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.

There was a comprehensive policy for repeat prescribing. Individual GPs were responsible for checking that repeat prescriptions were issued with reference to the medicine review date for each patient. Repeat prescriptions were handed into the practice, there was a repeat prescriptions box in the waiting room or patients handed them to the reception staff.

Requires improvement

# Are services safe?

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Up-to-date copies of directions were available for staff to follow and records showed that the nurse had received appropriate training to administer vaccines.

The practice conducted medicines audits and had done so with the prescribing advisors from the local clinical commissioning group (CCG) twice during the last twelve months. Changes had been made to medicines the practice prescribed following advice from the prescribing advisor. Patterns of prescribing of antibiotic, hypnotic, pain relief and anti- psychotic medicines were within the normal ranges expected for such a practice.

## Cleanliness and infection control

Most areas of the premises were clean and tidy. We found dust on some high surfaces in the treatment room and there was damage to the plaster on the wall in that room which could act as a site for harbouring bacteria. The consulting rooms were clean, tidy and uncluttered. The rooms were well stocked with personal protective equipment (PPE) including a range of disposable gloves, aprons and coverings. We saw that antibacterial gel was available in the reception area for patients and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice. There were clinical waste disposal contracts. Spillage kits were available.

One of the practice nurses was the designated clinical lead for infection control and had receive training appropriate for them to take on this role. There was an infection control policy and audits had been carried out. The last audit had taken place in 2014 and had resulted in a number of changes such as: wall mounted sharps bins and soap dispensers, disposable privacy curtains and foot operated pedal bins where needed. There were cleaning schedules and an audit system to monitor the cleanliness of the building and equipment. However we saw that some issues raised in a recent audit had yet to be addressed.

## Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and there was a schedule for this. The practice had a contract with a reputable medical devices servicing company to do this work.

## Staffing and recruitment

Some personnel records confirmed that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and criminal record checks through the Disclosure and Barring Service. All GPs and nurses had had criminal records checks. Most though not all staff records contained the required information. There were records to show that the professional registration checks for staff with the Nursing Midwifery Council or the General Medical Council had been completed and this included locums deployed at the practice.

We saw there was a rota system in place for all the different staffing groups to ensure that there were enough staff on duty. The rota system ensured that staff, including GPs, nurses and administrative staff covered each other's annual leave.

## Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor most risks to patients, staff and visitors. These included annual and monthly checks of the building and its environment, staffing, dealing with emergencies and managing equipment. There were health and safety processes, for example a fire risk log. There was a system governing security of the practice. Visitors were required to sign in and out using the dedicated book in reception and staff checked the identity of visitors. There were key pads on doors to appropriate rooms to prevent unauthorised access.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. There was emergency equipment available including medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of this equipment. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar levels). We checked the emergency medicines, they were in date and reviewed regularly. Most staff had received training in basic life support (BLS) and there was further training planned.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather,

Requires improvement

# Are services safe?

unplanned sickness and access to the building. There were local contingency plans for the outbreak of disease for example, Ebola. There was a fire risk assessment in place that was reviewed by the practice manager.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Care and treatment followed national best practice and guidelines. For example, the emergency medicines and equipment held by the practice were consistent with the guidelines issued by the Resuscitation Council (UK). The GPs and nurses used the guidelines from the National Institute for Health and Care Excellence (NICE) and other best practice. For example, the practice use of ambulatory blood pressure monitoring, recommended by NICE as the most accurate method for confirming a diagnosis of hypertension (raised blood pressure). The practice used the Cardiff health check, recognised by the Royal College of General Practitioners, for assessing the health needs of patients with a learning disability. Staff also used local guidelines and referral pathways that had been produced by the local clinical commissioning group (CCG).

There was a range of nurse appointments available to patients through a number of clinics for chronic disease management – such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease (COPD). There were GP leads for specialities such as diabetes. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice. Interviews with staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

### 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, managing patient reviews and medicines management.

There had been some prescribing audits carried out in cooperation with the local prescribing advisors. The practice had undertaken a range of other audits. These had included audits concerning diabetic treatment, minor surgery and the treatment of gout. We saw that there had been changes to practice following the first audits and results shared amongst the GPs and nurses, There had been follow up audits to ensure that the planned changes had been implemented and the improvements sustained. There was no overall audit plan for the practice and some of the audits did not specify when the follow up audit cycles would take place. There was no evidence of a structured approach for example, audits aimed at improving care for the practice's larger patient groups.

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 used the information collected for the QOF and reviewed performance against national screening programmes.

The QOF results indicated that the practice often achieved well in terms of diagnosing patients with illness such as depression, hypertension, chronic kidney disease and rheumatoid arthritis. Also evidence showed that the practice had managed a sustained improvement over the last few years. The practice was aware when this aspect of performance had fallen. For example in the diagnosis of mental health the practice was historically below the level that might be expected for the area. The practice had reviewed its performance and this year had seen a marked increase, up by one third, in the diagnosis of patients suffering mental ill health. The QOF results also showed that patients were generally receiving the routine checks and reviews necessary for the management of their long term conditions.

### Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. Recently appointed members of staff we spoke with told us that this programme had been completed but this was not reflected in their staff files.

There was no training schedule to evidence what training staff had previously received or were due to receive. This was work that had been taken on by a new staff member and the practice accepted that more work was needed to record staff training and to identify and bridge any gaps. There was a plan to address these issues. The practice was closed for half a day a month to accommodate training that was organised by the practice or by the local clinical commissioning group.

Good

# Are services effective?

## (for example, treatment is effective)

The practice nurses held internal meetings where recent professional developments and best practice were discussed. They told us the practice wholeheartedly supported them in their role and encouraged further training. We saw examples of staff who had been supported, financially and in terms of study leave, to obtain relevant degrees and other qualifications.

All GPs were up to date with their yearly continuing professional development requirements and they had been or were in the process of being revalidated. (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).

Administrative staff were appraised annually. Some of the staff we spoke with about their appraisal said they had found the process useful. Other however felt that it was "tick box" exercise and did not help, for example, to identify training needs or provide an opportunity to discuss any problems. We looked at the records of appraisal. They contained a pre appraisal questionnaire, aimed at identifying training and development needs as a preliminary to the formal appraisal process. There was little documentary evidence of progress beyond this. However it was clear that many staff had received relevant training and did feel very supported by the practice.

### Working with colleagues and other services

The practice worked with other professionals such as, district nurses, social services, GPs and other specialists. The practice made referrals by letter, fax, through the "choose and book" system and electronically. The practice received test results and letters from the local hospital including discharge summaries, from the out-of-hours GP services and the 111 service both electronically and by post. There were processes to manage this correspondence and staff understood their responsibilities in relation to these. Staff said that the processes worked well and we saw that correspondence was dealt with in a timely fashion.

The practice liaised with other healthcare and social care professionals such as the district nurses, community matrons and social care coordinators.

The practice was commissioned for the unplanned admissions enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). It had identified the most vulnerable patients, they had been contacted and informed who was their care co-ordinator and named GP. There was a process to follow up patients discharged from hospital.

### Information sharing

All information about patients received from outside of the practice was captured electronically in the patients' records. For example, letters received were scanned and saved into the patients' records by the practice. Information from the out-of-hours service (OOH) was received by fax or by e-mail and was scanned into patients' notes

There were systems to help ensure information regarding patients was shared with the appropriate members of staff. Individual cases were analysed at both formal and informal meetings amongst and between GPs and nurses. We looked at the minutes of some meetings and saw that there was detailed consideration of the health, social and welfare factors that affected the patients discussed.

### Consent to care and treatment

The GP and nurses we spoke with were aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Nurses, who were involved in offering emergency contraception showed strong knowledge about Gillick competency and other social factors such as grooming and safeguarding.

The practice carried out joint injections. The practice provided appropriate information and consent was sought from patients prior to the procedure being carried out.

### Health promotion and prevention

Staff told us that all new patients were offered a health check. The practice also offered NHS Health Checks to all its patients aged 40-75. Staff told us of several instances in the last year when these checks had led to the early diagnosis of conditions for example high blood pressure.

There was a range of leaflets available to inform patients on health care issues. These included smoking cessation, diet and healthy living. There was more detailed information

Good

# Are services effective?

## (for example, treatment is effective)

about long-term conditions including mental health, cancer and asthma. There were details of organisations that were available to help patients suffering from these, and other, conditions.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. During the last two years' the performance for child immunisations ranged from approximately 96%- 100% of all immunisations compared with the local clinical commissioning group (CCG) averages of 90 – 95%. The practice also did well in providing influenza vaccinations to the elderly achieving results that were in line with the CCG and national performance.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We observed throughout the inspection that the practice staff were courteous caring and very helpful to patients both attending at the reception desk and on the telephone. There was a substantial Nepalese community within the practice and we saw staff trying particularly hard to explain procedures and concepts, such as routine check-ups and specialist referrals, to patients so that they understood the concepts and to educate them in the benefits.

Patients completed comment cards to tell us what they thought about the practice. We received two completed cards and we spoke with four patients. All were positive about the service they had experienced. Results from the national GP patient survey showed that approximately 80% of patients said the last GP they saw or spoke to was good at treating them with care and concern this was in line with the national average. The patient survey also showed that approximately 77% of patients said that the last time they saw or spoke to a GP, that GP was good or very good at involving them in decisions about their care. This was above with the national average. In answer to the same questions, when asked about nurses the results were in line with or above the national average.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. We saw that staff always knocked and waited for a reply before entering any of the rooms. All the consulting rooms had substantial doors and it was not possible for conversations to be overheard. The rooms were, if necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was necessary. The practice had a confidentiality policy in place and all staff were required to sign to say they would abide with this as part of their employment contract.

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

Patients said that the GPs and the nurse discussed their health with them and they felt involved in decision making about the care and treatment they chose to receive.

Results from the national GP patient survey showed approximately 87% said the last GP they saw or spoke to was good or very good at involving them about their care and explaining test and treatment to them. These were slightly higher than the national averages. The survey showed approximately 94% said the last nurse they saw or spoke to was good or very good at involving them about their care and explaining test and treatment to them. These were was significantly higher than the national averages.

Patients received appropriate information and support regarding their care or treatment through a range of informative leaflets. The patient record system used by the practice enabled GPs and the nurse to print out relevant information for the patient at the time of the consultation.

The service had access to a language service to support those patients whose first language was not English. Staff we spoke with told us they used this service as needed but often the Nepalese community, who were very self-supportive, brought their own interpreters with them.

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

The reception desk area was very small and it was difficult for the practice to promote privacy in this environment though there was a facility for patients to speak with staff privately if they wished to do so. There was supporting information to help patients who were carers on display in the waiting room.

The GPs carried out home visits to patients who were housebound or receiving end of life care. There were end of life care plans which included ensuring that urgently needed medicines were issued without delay. How to follow up with families who had suffered bereavement was a decision for individual GPs. Usually this took the form of a telephone call to the family and the offer of consultation, at a flexible time and location to meet the family's needs. Where appropriate the bereaved were offered counselling with a national charity specialising in this service.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice established patient participation group (PPG) in the last year. There was encouragement for patients to join the PPG posted on the practice's website. The PPG met quarterly. There were annual patient surveys. The practice responded to the concerns that were identified. We spoke with four members of the PPG who told us the practice had been responsive to their concerns. For example, the group had suggested that a sliding front door would be of great help to wheelchair bound patients or those with prams, the practice had had this installed.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements. For example in providing the sliding door the practice had liaised with NHS England and obtained a grant which assisted with the costs of the improvement.

The practice had a substantial Nepalese community and much of the information, such as notices about chaperoning, joining the PPG and emergency signage was displayed in both English and Nepalese.

### Tackling inequity and promoting equality

The practice had a proportion of minority groups for whom English was not their first language but it always recorded patient's language and ethnicity at registration.

The surgery had access to translation services. The building had access for disabled patients. Accessible toilet facilities were available for all patients attending the practice. There were baby changing facilities.

We heard staff making appointments. They were pleasant and respectful to the patients. They tried to accommodate the times that the patients asked for however, when they could not they talked with the patients to identify other suitable times. Patients had the choice of a male or female GP. There were longer appointments available to patients who needed them. The computer system flagged those who had already been identified as needing longer appointments. The practice recognised that many Nepalese patients had had little medical education about managing long term illness. When Nepalese patients were newly diagnosed with such conditions a double length appointment was made so that the staff had time to cover the education aspects in depth.

The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

### Access to the service

The practice was open for surgery hours 8.30 am – 6.30 pm Monday to Friday. There were a number urgent on the day appointments available in each session that is mornings and afternoons. There were extended surgery hours until 8.15pm on Mondays and Tuesdays, primarily for patients who were not able to get to the practice during standard working hours. There was a triage system where trained nurses assessed the patients' needs on the telephone and decided which appointment was suitable. We were told, and patients we spoke with confirmed, that patients responded well to this. However if patients said that they wished to see a GP an appointment was made. The practice provided a telephone consultation service for those patients who were not able to attend the practice. The service offered home visits to those patients who were housebound or too ill to attend the practice.

There were three questions in the GP patient survey about appointments: were patients able to get an appointment, was it convenient and was the experience good. Patients responded positively to all three questions. For the first two the answers were at or slightly above the national average. For the last question the satisfaction rate was 85% as opposed to the national average of 75%.

### Listening and learning from concerns and complaints

The practice had a system for handling concerns and complaints. The practice manager was designated to handle all complaints in the first instance. Information was available to help patients understand the complaints system, including in Nepalese. The policy was to accept complaints only if they were in writing. We discussed this with practice, they agreed that this might act as a barrier to some patients and that they would review the policy.

We looked at the record of complaints and at some individual complaints. Complaints were well recorded and there was a record of a thorough investigation which identified the issues. There was some evidence of learning

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

from complaints for example, we saw that one complaint was discussed at a critical event meeting. Complainants were offered an apology where the circumstances warranted it. Complainants were referred to the Health and Parliamentary Services Ombudsman if the matter could not be resolved and the practice complaints policy reflected this.

# Are services well-led?

Requires improvement

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

## Our findings

### Vision and strategy

The practice had a mission statement which included providing high quality safe care and of putting patient's needs at the heart of everything they do. Most staff we spoke with were aware of the statement and felt it was embedded in the practice. Staff tried to conduct themselves by these values, for example, trying to ensure that patients saw their own (preferred) GP whenever possible and trying to respond to patients needs to the best of their ability at all times. The GPs and the manager said they advocated an open door policy and all staff told us the GPs and practice manager were very approachable.

There was had been discussion amongst the GPs and staff about the strategic direction of the practice and there had been initiatives with other health providers to bring more, and better access to services. For example as part of the Prime Minister' Challenge Fund there was a GP available to a group of practices in the area from 8am to 8pm for acute problems.

### Governance arrangements

There was a range of mechanisms to manage governance of the practice. However evidence of their effectiveness was mixed. The policies we looked at were adequate though many needed to be brought up to date. The practice had started a structured review of policies but acknowledged there was much to do. There was a weekly partners' and clinical meeting this was structured, minuted and there was evidence of learning from it. However the learning was confined to the GPs and nurses. There was no evidence of spreading learning through wider communication.

Limited communication was evidenced in other areas. The practice had, historically, a very low diagnosis of patients' mental health problems and they had made a marked improvement. However there were some GPs who were unaware of the low diagnosis rate and of the practice's efforts to improve it. The practice could not say how they had come to identify the problem or what priority they accorded it.

The practice supported some excellent training for staff, but there was no system to identify what skills, as a whole, the practice required and what strategy should be implemented to achieve this. For example, the practice had provided comprehensive support to some nursing staff to develop, in other areas, particularly for the administration staff, training had, until very recently, been a neglected area.

In terms of managing risks there was also evidence of a lack of coordination. There was a very professional fire assessment and fire action log document but staff who needed to know about this were unaware of it. Sometimes the practice failed to make use of the skills it possessed in house. For example, nursing staff had been appraised annually by the practice manager and most staff felt the appraisal was of some value. However the practice had a nurse who had completed a course as a nurse appraiser who could have made the appraisal more relevant to nursing and reduced the practice manager's workload at the same time.

There were meetings between partners, between nurses and between administrators but there were no overall practice meetings, or any other mechanism to share learning and direction across the whole practice.

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

There was a patient participation group (PPG). Minutes from meetings and results of surveys showed that the practice acted on feedback. There was a representative from the Nepalese community on the PPG. There was an annual survey of patients. This identified concerns and suggestions that included, amongst other things, dealing with repeat prescriptions and concerns over the on-line booking system. The practice had reviewed these areas and had action plans to address the issues raised.

We saw evidence of staff influence how the practice was run. Staff suggestions had included the way the telephone triage was operated and the management of workflow in the administration office. In both cases suggestions for improvement had been adopted by the practice.

### Management lead through learning and improvement

The practice staff told us they worked well together as a team and there was evidence of this is the way that morning breaks were arranged between the reception and the administration staff.

Staff had protected learning time during the monthly half-day closure of the practice set aside for learning and development. However we did not see any long term

# Are services well-led?

Requires improvement

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

strategy to link the learning and development opportunities to the practice's needs. The practice GPs and nursing staff accessed on-going learning to improve their clinical skills and competencies, for example, attending specialist training for conditions such as diabetes and asthma. GPs and nursing staff attended external forums and events to help ensure their continued professional development.

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 17 HSCA (RA) Regulations 2014 Good governance<br>**The provider failed to establish and operate effectively systems to:**<br>**assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)**<br>Because:<br>1. he approach to reporting, recording and monitoring significant events, incidents and accidents was not sufficiently systematic to capture events from all areas of the practice<br>2. There was a lack of systematic approach to governance, including maintaining the cleanliness and fabric of the building. |