

# St Albans Medical Centre

## Quality Report

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

## Ratings

### Overall rating for this service

Good 

Are services safe?

Good 

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 St Albans Medical Centre on 11 October 2016. The overall rating for the practice was requires improvement, and the practice was rated as inadequate for safety. The full comprehensive report on the October 2016 inspection can be found by selecting the 'all reports' link for St Albans Medical Centre on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

Following the October 2016 inspection, the practice submitted an action plan, outlining what they would do to meet the legal requirements in relation to the breach of regulations 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this announced focussed inspection on 25 April 2017 to check that the practice had followed their plan and to confirm that they now met the legal requirements. This report covers our findings in relation to those requirements.

Overall the practice is now rated as good.

Our key findings were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment and to carry out their roles effectively. Processes were in place to ensure that staff undertook training updates at the recommended intervals.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- The partners were clear about the performance of the practice and we saw evidence of action they had taken to address areas of below-average performance. Data showed patient outcomes were comparable to the national average and the practice had improved their processes in order to address their previously high exception reporting rate.
- Clinical audits had been completed and we saw evidence of these being used to improve patient care.
- The practice had a number of policies and procedures to govern activity; these had been reviewed and amended following issues raised during the previous inspection.

# Summary of findings

- Information about services and how to complain was available and easy to understand; however, not all complaint responses included information about how the complaint could be escalated.

There were three areas of where the provider should make improvements.

The provider should:

- Continue to ensure that they are identifying carers so they can be signposted to appropriate support.
- Ensure that all complaint responses include details of how the complaint can be escalated.
- Continue to work to develop their Patient Participation Group.

**Professor Steve Field CBE FRCP FFPH FRCGP**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Good



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were comparable to national averages and that following the initial inspection the practice had reviewed their processes in order to address areas of below average achievement.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Good



### Are services caring?

The practice is rated as good for providing caring services.

Good



# Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. Following the survey the practice had addressed areas where they felt improvements were indicated and had then carried-out their own survey in order to measure their success.
- Survey information we reviewed showed that 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 accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice 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. For example, the practice offered a number of additional enhanced services for the benefit of their patients, such as extended opening hours and minor surgery.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff. However, not all complaint responses included details about how the complaint could be escalated.

Good



## Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.

Good



# Summary of findings

- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.
- The partners encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. For example, the practice had carried-out their own patient survey.
- There was a focus on continuous learning and improvement at all levels.
- GPs who were skilled in specialist areas used their expertise to offer additional services to 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

The provider had resolved the concerns relating to the issues identified in the safe, effective and well-led domains identified at our inspection on 11 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

In particular:

- During the initial inspection we found that the safety of care for older people was not a priority, and we saw examples where the practice had failed to contact patients to arrange care following the receipt of test results. When we re-inspected the practice on 25 April 2017 we found that the practice had introduced a new system to ensure that follow-up action required following the receipt of test results was carried-out and that an audit trail was available.

Good



### People with long term conditions

The provider had resolved the concerns relating to the issues identified in the safe, effective and well-led domains identified at our inspection on 11 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

In particular:

- During the initial inspection we found that the practice did not have adequate processes and safety nets in place to ensure that patients with some long-term conditions were adequately monitored and the practice had higher than average exception reporting rates for care of some long-term conditions. When we re-inspected the practice on 25 April 2017 we found that the practice had changed their process for inviting patients with long-term conditions for annual reviews, and as a result, their exception reporting rate had improved.

Good



### Families, children and young people

The provider had resolved the concerns relating to the issues identified in the safe, effective and well-led domains identified at our inspection on 11 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

In particular:

Good



# Summary of findings

- During the initial inspection we found that the practice did not have a system in place to ensure that results were received for all samples sent for analysis as part of the cervical screening programme, and that there was no system to ensure that patients with an abnormal result were followed-up. When we re-inspected we found that the practice had introduced a system of monthly patient records searches to ensure that sample results were received and patients were followed-up where necessary.

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

The provider had resolved the concerns relating to the issues identified in the safe, effective and well-led domains identified at our inspection on 11 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good



## **People whose circumstances may make them vulnerable**

The provider had resolved the concerns relating to the issues identified in the safe, effective and well-led domains identified at our inspection on 11 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

In particular:

- During the initial inspection we found that the practice had failed to ensure that all non-clinical staff had received regular safeguarding training. When we re-inspected we found that all staff had completed safeguarding training within the recommended timeframe.

Good



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

The provider had resolved the concerns relating to the issues identified in the safe, effective and well-led domains identified at our inspection on 11 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good





# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Two hundred and forty four survey forms were distributed and 116 were returned. This represented approximately 2% of the practice's patient list.

- 99% of patients found it easy to get through to this practice by phone compared to the CCG average of 69% and national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and national average of 85%.
- 94% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and national average of 85%.
- 90% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG and national average of 78%.

As part of our previous inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards, and 22 of these were positive about the standard of care received. Patients commented that staff at the practice were kind and caring and that they did not feel rushed during appointments.

We spoke with seven patients during the initial inspection. Overall, patients we spoke to said they were satisfied with the care they received and thought staff were approachable, committed and caring; however, one patient mentioned an incident where they had been prescribed a medicine without the side effects being clearly explained. During the follow-up inspection we spoke with one patient, who also told us they were satisfied with the quality of care at the practice.

# St Albans Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was made up of a CQC Lead Inspector and a GP specialist adviser.

## Background to St Albans Medical Centre

St Albans Medical Centre provides primary medical services in Kingston to approximately 6850 patients and is one of 23 practices in Kingston Clinical Commissioning Group (CCG).

The practice population is in the least deprived decile in England. The proportion of children registered at the practice who live in income deprived households is 9%, which is lower than the CCG average of 12%; and for older people the practice value is 11%, which is lower than the CCG average of 13%. The practice has a smaller proportion of patients aged 20 to 34 years than the CCG average, and a slightly larger proportion of patients aged 35 to 54 years. Of patients registered with the practice, the largest group by ethnicity are white (80%), followed by asian (11%), mixed (5%), black (2%) and other non-white ethnic groups (3%).

The practice operates from a three-storey converted residential premises. A small amount of car parking is available at the practice, and there is space to park in the surrounding streets. The reception desk, waiting area, and four consultation rooms are situated on the ground floor. The practice manager's office and three consultation rooms are situated on the first floor; and the second floor consists of two locked storage areas. The practice has access to four doctors' consultation rooms and three nurses' consultation rooms.

The practice team at the surgery is made up of one part time female GP, one full time male GP and one part time male GP who are partners, in addition, one part time female salaried GP is employed by the practice, and they have one trainee GP (Registrar) on a year-long placement. In total 25 GP sessions are available per week; and in addition seven Registrar sessions are offered. The practice also employs three female nurses and one healthcare assistant. The clinical team are supported by a practice manager, deputy practice manager, five receptionists, two secretaries and two administrators.

The practice operates under a General Medical Services (GMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice is open between 8am and 6:30pm Monday to Friday. Appointments are from 7:30am to 11:20am every morning, from 1:30pm to 6:30pm on Monday, Wednesday and Thursday afternoons, from 3:00pm to 6:30pm on Tuesday afternoons and from 3:30pm to 6:30pm on Friday afternoons. Extended hours surgeries are offered daily between 7:30am and 8am.

When the practice is closed patients are directed to contact the local out of hours service.

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

# Detailed findings

## Why we carried out this inspection

We undertook a comprehensive inspection of St Albans Medical Centre on 11 October 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe services, and requires improvement for providing effective and well led services. The full comprehensive report on the October 2016 inspection can be found by selecting the 'all reports' link for St Albans Medical Centre on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

We issued a warning notice to the provider in respect of safety and informed them that they must become compliant with the law by 16 December 2016. On 15 December 2016 the practice submitted evidence demonstrating that they had complied with the requirements of the warning notice. They also provided an action plan, outlining how they would meet the legal requirements in relation to the breach of regulations 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook an announced comprehensive inspection of St Albans Medical Centre on 25 April 2017. This inspection was carried out to check that the practice had followed their plan and to confirm that they now met the legal requirements.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 25 April 2017. During our visit we:

- Spoke with a range of staff including GPs, nursing staff, reception staff and the practice manager and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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).

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

# Are services safe?

## Our findings

**At our previous inspection on 11 October 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of significant events, safeguarding infection control, prescribing and storage of medicines were not adequate.**

**We issued a warning notice in respect of these issues and found arrangements had significantly improved when we undertook a follow up inspection of the service on 25 April 2016. The practice is now rated as good for being safe.**

### Safe track record and learning

During the initial inspection we found that there was a system in place for reporting and recording significant events, but we found that the process of recording and discussing significant events lacked cohesion; for example, we found that details about significant events were not always saved in the same place. Following the inspection, the practice had reviewed and made changes to their process. They had introduced a standardised recording form, and completed forms were all submitted to the practice manager who would co-ordinate the process. The completed forms were distributed to relevant members of staff with an accompanying sheet which was signed once each individual had read the form. The practice had recorded four significant events during the six months since the previous inspection, and we reviewed the recording forms and were shown the sign sheet for each of these. The practice had introduced dedicated quarterly meetings for discussing significant events and complaints, during which each incident was reviewed and discussed. We reviewed the minutes of the one meeting which had been held (the next meeting was scheduled for the same week as the re-inspection).

### Overview of safety systems and process

During the initial inspection we found that the practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse; however, these were not always effective. During the follow-up inspection we found:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly

outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities. GPs and nurses were trained to child protection or child safeguarding level 3 and administrative staff were trained to level 1. During the initial inspection we found that some administrative staff had not completed training in child safeguarding. When we returned for the follow-up inspection we found that all staff were up to date with this training, and that the practice manager had put a process in place to monitor when staff training was due.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. During the initial inspection we observed that the practice was not using single-use items in all cases recommended by current infection control guidance; for example, they did not use single-use tourniquet straps or lubricant gel sachets. Following the initial inspection the practice began using single-use items in line with infection control best practice. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken; however, at the time of the initial inspection there had not been an audit conducted in the past 12 months, and the practice had not resolved the issues highlighted in the last audit, conducted in August 2015, relating to the taps and sink areas in the consulting rooms (we were told that they had recently submitted an application for a grant to undertake the work needed). When we re-inspected we found that the practice had completed an internal infection control audit. They had created an action plan to address areas for improvement, and were monitoring their progress with these.

## Are services safe?

- The arrangements for managing emergency medicines and vaccines in the practice kept patients safe; however, during the initial inspection we found that processes for repeat prescribing were unsafe, as we saw evidence that patients were being prescribed high-risk medicines without the required monitoring taking place. We were also told about examples of administrative staff issuing prescriptions outside of the remit of their role, as set out in the practice's prescribing policy. Following the inspection, the practice put new processes in place to ensure that the appropriate monitoring was being carried-out and that the repeat prescribing process was safe; they updated their repeat prescribing policy with these changes. During the follow-up inspection we saw evidence that the prescribing of high-risk medicines was appropriate.
  - The practice carried out medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
  - Blank prescription forms and pads were securely stored and there were systems in place to monitor the use of prescription pads; however, during the initial inspection we found there was no log kept of blank prescription sheets. Following this the practice introduced a log of blank prescription sheets, which they showed to us. Some stocks of blank prescription sheets were stored in a locked cupboard in the unlocked reception area; however, having been made aware during the inspection that this arrangement did not comply with NHS guidance, the practice confirmed that they had moved this stock to a locked cupboard in one of the lockable consultation rooms.
  - Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).
  - At the time of the initial inspection the practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse). They had a log in place to record the stock level of these drugs; however, the storage and disposal arrangements for controlled drugs were not adequate and did not adhere to legal requirements. Following the initial inspection the practice had decided to no longer stock these medicines, and we saw evidence that all controlled drugs had been securely destroyed.
  - We reviewed three personnel files relating to the three members of staff who had started at the practice following the initial inspection. We found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, and registration with the appropriate professional body.
- ### Monitoring risks to patients
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried-out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
  - Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.
- ### Arrangements to deal with emergencies and major incidents
- The practice had adequate arrangements in place to respond to emergencies and major incidents.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

## Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.



# Are services effective?

(for example, treatment is effective)

## Our findings

**At our previous inspection on 11 October 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of the performance of the practice, clinical audits, staff appraisals and training, and monitoring patient care needed improving.**

**These arrangements had significantly improved when we undertook a follow up inspection on 26 April 2017. The provider is now rated as good for providing effective services.**

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through audits.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). At the time of the initial inspection the most recent published results were for the 2014/15 reporting year where the practice had achieved 100% of the total number of points available; however, they had a higher than average exception reporting rate of 14% (compared to a CCG average of 10% and national average of 9%). The practice had showed us data for the 2015/16 reporting year, which at the time was not yet validated, and this showed that the practice had again achieved 100% of the total number of points available, and their exception reporting rate remained at 14% (compared to a CCG average of 12% and national average of 10%). They explained that they thought the high

exception reporting rate may have been due to them registering a large number of patients during the last quarter of the reporting year from a nearby practice which had closed.

At the time of the re-inspection in April 2017, the 2015/16 data had been validated. This showed:

- Overall performance for diabetes related indicators were better than the CCG and national averages. The practice achieved 100% of the total QOF points available, compared with an average of 96% locally and 90% nationally. Their exception reporting rate for diabetes indicators was 17%, compared to a CCG average of 15% and national average of 12%.
- The percentage of diabetic patients who had a record of well controlled blood pressure in the preceding 12 months was 81%, which was comparable to the CCG average of 81% and national average of 78%. The practice's exception reporting rate for this indicator was 12%, compared to a CCG average of 13% and national average of 9%. This was an improvement compared to the practice's 2014/15 exception rate of 16%.
- The percentage of diabetic patients with a record of well controlled blood glucose levels in the preceding 12 months was 89%, compared to a CCG average of 83% and national average of 78%. The practice's exception reporting rate for this indicator was 21%, compared to a CCG average of 17% and national average of 13%.
- The practice had 30 patients diagnosed with dementia and 72% of these patients had had their care reviewed in a face to face meeting in the last 12 months, which was below the CCG and national average of 84%. The practice's exception reporting rate was 3% compared to a CCG average of 6% and national average of 7%. The practice's achievement for this indicator had declined compared to the previous reporting year when 88% of eligible patients received this intervention.
- The practice had 49 patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses, and had recorded a comprehensive care plan for 95% of these patients, compared to a CCG average of 96% and national average of 89%. The practice's exception reporting rate was 25% compared to a CCG average of 12% and national average of 13%.

During the follow-up inspection the practice explained that during the 2016/17 QOF reporting year, they had changed their processes in order to address their exception

# Are services effective?

## (for example, treatment is effective)

reporting rate. For example, they had previously invited patients with long-term conditions for annual reviews by letter and they explained that they would send three letters and would except the patient if they failed to respond. During the 2016/17 year they had begun phoning patients who failed to respond to two invitation letters, to encourage them to attend; they would then wait until the end of the reporting year to except patients who had not attended.

The practice provided us with their 2016/17 QOF data, which at the time of the inspection was not yet validated. This showed that that the practice had successfully reduced their exception reporting rate for a number of indicators. Their overall exception reporting rate for all clinical indicators was 10% (compared to 14% for the previous year).

- For diabetes indicators the overall exception rate was 13% (compared to 17% for the previous year)
- For chronic obstructive pulmonary disease their overall exception rate was 16% (compared to 21% for the previous year)
- For asthma indicators their overall exception rate was 3% (compared to 11% for the previous year)
- For mental health indicators their overall exception rate was 4% (compared to 23% for the previous year)
- For dementia indicators their overall exception rate was 0% (compared to 14% for the previous year)

There were some areas where the practice's exception reporting rate had increased during the 2016/17 reporting year, for example, the overall exception rate for cancer indicators was 36% (compared to 24% for the previous year). The practice explained that they had identified a problem with the way that data was reported, and we saw minutes of a meeting where they had discussed this issue. Our review of their patient records system confirmed that the practice had completed patient reviews which had not been reported when the data had been downloaded.

There was evidence of quality improvement including clinical audit.

- There had been four clinical audits carried out since the last inspection, all of which were completed audits. We saw evidence that audit was being used to drive improvements in patient outcomes. For example, the practice had carried-out an audit of the care of patients with asthma, which showed that having put measures in

place following an initial audit, there was an increase in the proportion of patients with asthma who had attended an annual review, received an assessment of their inhaler technique and had a personalised action plan for managing their condition.

- The practice participated in local audits, national benchmarking and accreditation.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered an overview of topics including safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. Nursing staff had received updates on monitoring long-term conditions, such as training courses on the management of leg ulcers.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. At the time of the initial inspection, apart from one staff member, administrative staff had not received an appraisal for the past 18 months. At the time of the follow-up inspection we found that all relevant staff had received an appraisal. Nursing staff received regular appraisals where their learning and support needs were identified, and regular clinical supervision sessions were provided to trainee GPs.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to, and made use of, e-learning training modules and in-house training. At the time of the initial inspection we found that not all staff had completed training updates within guideline timescales, and the practice had no process for monitoring when staff had completed training. At the time of the follow-up inspection we found that the



# Are services effective?

## (for example, treatment is effective)

practice had introduced a system for monitoring when staff were due for update training. We reviewed five staff files and found that training had been completed within the recommended intervals.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their computer system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a two-monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

During the initial inspection we found that the practice did not have an effective system in place to ensure that patients were reviewed once the results of tests had been received. We were told that when samples were taken from patients for diagnostic tests, they were instructed to contact the practice to be told the results; however, there was no process in place to ensure that vulnerable patients were followed-up. When we returned for the re-inspection, we found that the practice had introduced a new system which allowed GPs to send messages to clerical staff via the patient records system. This system was being used by GPs to instruct clerical staff of action to take in relation to test results (for example, arranging further tests or booking an appointment for the patient).

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Smoking cessation advice was available from the healthcare assistant.

For the 2015/16 reporting year, the practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 83% and the national average of 81%. At the time of the initial inspection there was no practice-wide process for contacting women who had failed to attend for their cervical screening test; however, some nurses told us that they would telephone patients who had failed to attend; there was no failsafe system in place to ensure results were received for all samples sent for the cervical screening programme and the practice did not have a system in place to follow up women who were referred as a result of abnormal results. Following the initial inspection the practice began running monthly reports to identify any results which had not been received, and those which required follow-up by the nurse. Patients who had failed to attend for an appointment for a smear test were contacted by phone to invite them for another appointment.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening and the rate of attendance amongst the practice's patients was comparable to local and national averages.

Data from 2015/16 for childhood immunisation rates for the vaccinations given were higher than the national averages. There are four areas where childhood immunisations are

## Are services effective? (for example, treatment is effective)

measured; each has a target of 90%. The practice achieved the target in four out of four areas. These measures can be aggregated and scored out of 10, with the practice scoring 9.4 (compared to the national average of 9.1).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# Are services caring?

## Our findings

**At our previous inspection on 11 October 2016, we rated the practice as good for providing caring services.**

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Screens were provided most consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. During the initial inspection we noted that one consultation room used by a nurse which did not have a screen or curtain. When we returned for the re-inspection a curtain had been fitted in this room.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We spoke with a member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) and national average of 88%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 83% and national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 83% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 86%.

- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

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

Patients told us 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 and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received during the initial inspection were also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 82% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 81%.
- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 86%.

The practice had identified that there were some areas highlighted by the NHS GP Patient Survey where they would like to improve. They had discussed these with staff in order to raise awareness and encourage staff to reflect on and improve their approach to consultations. They had then completed their own survey, which included 104 patient responses. The practice's survey found:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to their previous achievement of 82%.
- 95% of patients said the last nurse they saw was good at explaining tests and treatments compared to the compared to their previous achievement of 86%.

## Are services caring?

- 91% of patients said the last GP they saw was good at involving them in decisions about their care compared to their previous achievement of 81%.
- 91% of patients said the last GP they saw was good at involving them in decisions about their care compared to their previous achievement of 83%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

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

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. At the time of the initial inspection the practice had identified 59 patients as carers (less than 1% of the practice list). When we returned for the follow-up inspection the practice had 65 carers on their register. The practice provided annual health checks and vaccinations to carers. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP sent them a letter. This was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**At our previous inspection on 11 October 2016, we rated the practice as good for providing responsive services.**

### Responding to and meeting people's needs

The practice 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. For example, the practice offered a number of additional enhanced services for the benefit of their patients, such as extended opening hours and minor surgery.

- The practice offered a 'Commuter's Clinic' every morning from 7:30am to 8:30am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.

### Access to the service

The practice was open between 8:00am and 6:30pm Monday to Friday. Appointments were from 7:30am to 11:20am every morning, from 1:30pm to 6:30pm on Monday, Wednesday and Thursday afternoons, from 3:00pm to 6:30pm on Tuesday afternoons and from 3:30pm to 6:30pm on Friday afternoons. Extended hours surgeries were offered daily between 7:30am and 8:00am. In addition to pre-bookable appointments that could be booked up to 12 weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to or better than local and national averages.

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 76%.
- 99% of patients said they could get through easily to the practice by phone compared to the CCG average of 69% and national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Requests for home visits were recorded by reception staff and passed to the duty doctor. A doctor would then contact the patient by phone to assess whether a home visit was required. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

### Listening and learning from concerns and complaints

The practice had an effective 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.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that leaflets were available to help patients understand the complaints system, and information was also available on the practice's website.

During the follow-up inspection we looked at the two complaints which had been received since the initial inspection and found these were satisfactorily handled and dealt with in a timely way, with openness and transparency. However, we noted that one of the response letters did not include information about how the complaint could be escalated. All complaints were discussed in detail during dedicated quarterly meetings.

# Are services well-led?

Good 

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

## Our findings

**At our previous inspection on 11 October 2016, we rated the practice as requires improvement for providing well-led services as there was no evidence that the vision of the practice had been embedded with staff, the governance arrangements with respect of managing risks were not well developed, there was a lack of understanding about the performance of the practice, there was little evidence of improvements resulting from clinical audits being shared and well embedded, and the PPG lacked clarity about their role.**

**These arrangements had significantly improved when we undertook a follow up inspection on 25 April 2017. The practice is now rated as good for being well led.**

### Vision and strategy

The practice delivered high quality care and promoted good outcomes for patients.

- The practice had a statement of purpose which outlined its objective to provide a high standard of clinical care in a safe environment, and to be courteous, approachable, friendly and accommodating to patients.
- During the initial inspection we found that the practice had some plans for the future with regards to succession planning; however, they had not developed a clear strategy for the future and did not have a business plan. When we returned for the follow-up inspection the practice had created a formal business plan.

### Governance arrangements

The practice had a governance framework which supported the delivery of their service. This outlined the structures and procedures in place and ensured that:

- There was a staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were available to all staff.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

However, during the initial inspection we found that governance arrangements were not always robust:

- At the time of the initial inspection the partners did not have a comprehensive understanding of the performance of the practice; for example, they were unaware that they had a higher than average QOF exception reporting rate. When we re-inspected we found the partners were clear about the practice's performance and had taken steps to make improvements in areas where this was necessary. We noted that the practice was in the process of having problems with their QOF data quality investigated.
- During the initial inspection we found that clinical audits were carried out, but there was little evidence of these resulting in improvements for patients and learning points being embedded. When we re-inspected the practice we found that four clinical audits had been carried out since the initial inspection, all of which showed an improvement in patient outcomes between the initial audit and the re-audit.

### Leadership and culture

Staff told us the partners were approachable and listened to staff; however, during the initial inspection we noted that formal opportunities to provide feedback, such as appraisals, had not been provided. When we re-inspected the practice we found that all staff who were eligible for an appraisal had received one.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.

# Are services well-led?

Good 

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice encouraged and valued feedback from patients, the public and staff.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. During the initial inspection we found that the PPG met regularly; however, members we spoke to explained that there was a lack of clarity about the role of the PPG. During the re-inspection we spoke to one long-standing member of the PPG who was positive about their personal experience of the practice. They explained that the PPG had been less active recently due to several key members leaving; however, the practice did consult members on key issues, and work was being done to recruit additional members in order to revive the group.

- The practice had gathered feedback from staff through staff meetings and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

## **Continuous improvement**

There was a focus on continuous learning and improvement at all levels within the practice. The management team had been responsive to areas highlighted for improvement during the initial inspection, and we saw evidence that these had been carefully considered and that effective solutions had been introduced, which involved staff members at all levels. For example, in order to ensure that patients who were referred for tests were subsequently followed-up, the practice had begun to make use of the “tasks” facility within their patients records system; this ensured that there was an auditable process for GPs to instruct clerical staff about follow-up actions (such as calling the patient in for a review) once test results were received.