Dr Asma Moghal

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Moghal's Practice on 11 March 2016. Overall, the practice is rated as requires improvement.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to inform practice management about incidents and near misses. However, the records of these events were brief and learning outcomes were minimal. There was no evidence to show patients received an apology.
- Risks to patients were assessed and managed, with the exception of those relating to recruitment checks and infection control.
- Data showed patient outcomes were comparable to the national average. We saw no evidence of completed audits having been carried out and we saw no evidence that audits were driving improvements to patient outcomes.
- The majority of patients said they were treated with compassion, dignity and respect.
- Urgent appointments were usually available on the day they were requested. However, patients reported that they did not receive timely care when they needed it.
- There was limited information about services. Translation services were available when requested.
- The practice had a number of policies and procedures to govern activity, but some were generic and did not have practice specific information or were overdue a review.

The areas where the provider must make improvements are:

- Ensure that patients affected by significant events receive reasonable support and follow up.
- Ensure a programme of quality improvement including clinical audits is in place to improve outcomes for patients.
- Ensure patient group directions (PGDs) are completed and up to date in line with legislation.
- Ensure staff understand their responsibilities in relation to the Mental Capacity Act 2005.
- Ensure that recruitment checks comply with Schedule 3 requirements.

Summary of findings

- Ensure infection prevention and control audits are carried out annually by trained staff.
- Ensure that all documents and processes used to govern activity are practice specific and are up to date. Including, updating the Business Continuity Plan.
- Ensure the appointment system is reviewed to improve patient access.
- Ensure there are systems in place to monitor blank prescriptions.
- Ensure risk assessments for DBS are carried out for staff who carry out chaperoning duties.
- Ensure that the complaints procedure is reviewed to comply with regulations.
- Ensure systems are in place to seek and act on feedback from patients for the purpose of evaluating and improving services.

In addition the provider should:

- Develop, document and communicate to all staff the practice vision, strategy and supporting business plan.
- Revise the support mechanisms available to staff and provide arrangements for all staff to attend formal meetings.
- Review system to identify carers in the practice.

Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall, it will be re-inspected within six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

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.

- Staff understood their responsibilities to raise concerns, and to inform the practice manager of incidents and near misses. However, patients did not always receive a verbal and written apology.
- Significant events were recorded but these were brief and the learning outcomes were minimal.
- Although some risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.
- The practice did not hold regular practice or governance meetings and issues were discussed on an ad hoc basis. Meeting were however held to discuss significant events with the practice team and these were recorded.
- Staff files were inconsistently maintained and did not demonstrate how staff had been effectively recruited and employed. There was a lack of evidence of references, interview notes or DBS checks for clinical and non-clinical staff.
- Safeguarding policies were in place to protect the safety of patients. Staff had an appropriate understanding of their responsibilities to safeguard patients.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- Data showed patient outcomes were comparable to the national average.
- Knowledge of and reference to national guidelines or medical alerts were inconsistent.
- There was no evidence of completed clinical audit cycles or that audit was driving improvements in performance to improve patient outcomes.
- Multidisciplinary working was taking place and there was some record keeping.
- There was limited recognition of the benefit of an appraisal process for staff. There was no evidence to show one to one discussions were taking place or that performance or learning and development was discussed.

Summary of findings

- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice similar to others for some aspects of care. For example, 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- The majority of patients said they were treated with compassion, dignity and respect.
- There was insufficient information available to help patients understand the services available to them. And the information that was available was in English only. However, translation services were available when requested.
- The practice did not have an effective system to identify patients who were carers.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. Patients told us they found it difficult to get pre-bookable appointments.
- Patients could get information about how to complain, but the practice only acknowledged formal written complaints. The practice did not demonstrate that complaints were always thoroughly recorded, investigated or that learning was shared effectively with staff. The practice did not provide evidence that all complaints were dealt with satisfactorily or in a timely way.
- The practice had good facilities and was equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

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

Summary of findings

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- The practice had a number of policies and procedures to govern activity, but some were generic and had not been up dated with practice specific information, others weren't dated or had not been reviewed.
- The practice did not hold regular practice or governance meetings and issues were discussed at ad hoc meetings.
- The practice had not proactively sought feedback from staff, although they did carry out an annual patient survey and they did not have an active patient participation group.
- Staff told us they had not received regular performance reviews and did not have clear objectives.

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

Inadequate

The provider was rated as inadequate for well-led and requires improvement for safe, effective and responsive and good for caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The provider was rated as inadequate for well-led and requires improvement for safe, effective and responsive and good for caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered a range of services to people with long term conditions. This included insulin initiation and anti-coagulation clinics.
- Longer appointments and home visits were available when needed. However, patients with long term conditions did not have a named GP. They did have a personalised care plan or structured annual review to check that their health and care needs were being met.

Families, children and young people

Requires improvement

The provider was rated as inadequate for well-led and requires improvement for safe, effective and responsive and good for caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were comparable to national averages for all standard childhood immunisations.

Summary of findings

- We received two comment cards where patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice's uptake for the cervical screening programme was 82%, which was higher than the CCG average of 72% and the national average of 74%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with health visitors.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as inadequate for well-led and requires improvement for safe, effective and responsive and good for caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered extended hours between 6.30pm and 8.00pm three days a week.
- The practice was proactive in offering online services and electronic prescription service as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered telephone consultations to all patients.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as inadequate for well-led and requires improvement for safe, effective and responsive and good for caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability. The practice gave a bypass contact telephone number, which allowed vulnerable people to call the surgery when they needed.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding

Summary of findings

information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, not all clinical staff could demonstrate they had completed relevant training for adult safeguarding in the past three years.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as inadequate for well-led and requires improvement for safe, effective and responsive and good for caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%.
- Performance for mental health related indicators was similar to the national average. For example, 92% of patients diagnosed with schizophrenia, bipolar effective disorder and other psychoses had had a comprehensive, agreed care plan documented in their records, in the preceding 12 months compared to a national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 393 survey forms were distributed and 109 were returned. This represented 2% of the practice's patient list.

- 83% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 57% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 90% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 74% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards of which 31 were positive about the standard of care received. Patients said they felt the practice offered a good service and staff were helpful and caring. Six comment cards highlighted concerns around difficulty in making appointments when needed and the long delays whilst waiting to be seen by a clinician.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice did participate in the NHS Friends and Family Test (FFT). FFT is a method of asking patients if they would recommend the practice to a friend or family member. The practices friends and families test score was 95%.

Dr Asma Moghal

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Dr Asma Moghal

Dr Asma Moghal's Practice, Becontree Medical Centre is a purpose built practice located in a residential area in Dagenham. There is suitable patient access to the premises and patient parking, including disabled parking. At the time of our inspection there were 5792 patients registered with the practice. Primary medical care is provided under a personal medical services (PMS) contract within NHS Barking and Dagenham Clinical Commissioning Group (CCG). The practice carried out regulated activities: surgical procedures, treatment of disease, disorder or injury, diagnostic and screening procedures, maternity and midwifery services and family planning.

Dr Asma Moghal is the registered manager of the practice and the lead GP. There are two female salaried GPs and they are supported by one male locum GP. The GPs undertake a combined total of 24 sessions per week. There is one full time nurse and two part time nurses, who do 21 nurse sessions per week. Non-clinical staff includes, a practice manager and seven administrative staff.

The practice is open between 8.00am and 6.30pm Monday to Friday. Appointments are from 9.00am to 11.30am every morning and 4.00pm to 6.30pm daily. There are no afternoon appointments on Wednesdays. The practice has extended hours at the following times between 6.30pm and 8.00pm Monday, Tuesday and Thursday and between 6.30pm and 7.00pm on Friday when patients could see the nurse. Out of hours service is provided by a different provider and can be accessed by calling the practice out of hours telephone number which is on the practice website and practice leaflet.

Twenty five percent of the practice population is aged under 14 years, which is higher than the national average (17%). They also have a lower patient population of people aged 65 years and over compared to national average. Life expectancy is lower for both male and female people, being 77 years for males and 81 years for females, compared to national averages of 79 years for males and 83 years for females.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

The provider was not inspected under the previous inspection regime.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 March 2016. During our visit we:

- Spoke with a range of staff (clinical and non-clinical) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of 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 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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was not an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and the lead GP and practice manager would make a written record of the event and decide on any necessary actions. The practice provided us with details of seven significant events that had occurred in the last 12 months. The recordings of these events were brief and learning outcomes were minimal. For example, a patient had called the practice on a Friday morning and spoken to a GP. The GP advised that they would call the patient back, but failed to do so. The patient then had to be treated by the out of hours services. The learning stated on the significant event document was for the GPs to better manage their workload when short staffed. Significant event records lacked detail although we saw evidence of the events being discussed in meeting minutes with the practice staff.
- We did not see evidence to show that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology or were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out analysis of clinical significant events. However, there were no systems in place for recording non-clinical significant events and staff told us near misses would be recorded onto the patient's records.

Overview of safety systems and processes

The practice systems and processes kept patients safe and safeguarded from abuse and included:

- 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 clinical staff discussed child safeguarding concerns at weekly clinical meetings and adult safeguarding concerns were discussed in fortnightly integrated care meetings. Staff demonstrated they understood their responsibilities and all had received online training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3. However, one GP could not demonstrate that they had completed relevant adult safeguarding training in the past three years. Nurses were trained to level 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones told us that they had had in house training and had completed online training for the role. However, the provider told us that Disclosure and Barring Service (DBS) checks had been applied for nursing and administrative staff between 2nd and 3rd of March 2016 and DBS certificates had not yet been received. (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). Staff could not always give examples of what they would be doing when carrying out chaperoning duties or where they would stand.
- The practice had not maintained appropriate standards of cleanliness and hygiene. We were told that a cleaner was contracted three days a week and administrative staff were responsible for the day-to-day general cleaning of the practice. However, there were no cleaning schedules or logs of tasks carried out by cleaner or administrative staff. At the time of our inspection, we found the disabled toilet was not clean, soap and hand sanitising gel was not available. Equipment was broken and toilet paper was placed at a height that may have been out of reach of some wheelchair users. The emergency alarm cord had been wound around a handle and could not be reached from the ground. Curtains in consultation rooms were clean and we were told they had been changed within the past 6 months; however there was no record kept of when the curtains were last changed. One of the practice nurses was the infection control clinical lead. There was no evidence of liaising with the local infection prevention teams to keep up to date with best practice. There was no infection control protocol in place. The lead infection control nurse had carried out the latest infection control audit on 29 February 2016 with a member of the administration team. However, the administration staff member had not completed their

online infection control training at the time they undertook the audit, and the nurse told us she had not completed any infection control training since 2009. The audit was incomplete and contained many notes to follow up or check with other members of staff. Annual infection control audits prior to February 2016 had not been undertaken since 2010. However, we saw evidence that action was taken to address any improvements identified as a result from infection control audit carried out in September 2010.

- There were some arrangements for the storage of medicines including emergency medicines and vaccinations. We found one medicine out of date and another medical device that had a patient's dispensing label, including the patient's name. The fridge temperatures were recorded daily to ensure the safe management of vaccinations and staff told us that expiry dates were checked every few weeks when stock was ordered but this was not recorded.
- Processes were in place for handling repeat prescriptions, which included the review of high risk medicines. The practice did not carry out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored but we did not see evidence of systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. When reviewed, we found 20 copies of PGDs, none of which had been signed by authorised individuals in line with the legislation. Since inspection, we have seen evidence of PGDs being completed, however these were due to expire 31 March 2016.
- We reviewed six personnel files and some appropriate recruitment checks had not been undertaken prior to employment. For example, three files did not have any evidence of references, we saw only two clinical staff had information about medical indemnity cover but these had expired in 2012 and 2014 and there were no records of Hepatitis B immunisation status for staff. Clinical staff files held information of qualifications and registration with the appropriate professional body.

Monitoring risks to patients

Risks to patients were assessed and managed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was no health and safety policy available but there was a poster in the reception area, which identified local health and safety representatives. The practice completed a fire risk assessment, health and safety audit and a Legionella risk assessment on 4 March 2016. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, there were no previous records of these assessments being carried out. We saw a fire alarm test log, which showed the fire alarm was tested weekly since September 2015. The log also stated that three evacuations had been carried during this period. There were no details of the evacuation or any action plans. All electrical equipment was checked on 5 March 2016 to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- 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 a panic button on all telephones in all the consultation and treatment rooms, which alerted staff to any emergency.
- All staff received basic life support training in March 2016, however there were no previous records to show training was undertaken annually by all staff. There were emergency medicines available in the treatment rooms.
- 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. The practice carried out weekly checks on expiry dates of the emergency medicines. However, we found the Emergency Medicines Check List contained incorrect details. For example, it detailed incorrect expiry dates of medicines.

Requires improvement

Are services safe?

- The practice had a generic business continuity plan in place for major incidents such as floods and IT failure. Staff told us it included staff lists however on review of the plan there were no staff lists, no contact details for staff and no lists of local services. Staff told us that the business continuity plan was kept in a folder in the office and there were no other copies kept offsite.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There was evidence that 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 systems in place to keep all clinical staff up to date with new NICE guidance and other alerts were ad -hoc.
- The GPs confirmed they had access to guidelines from NICE and attended CCG Medicines Management meetings quarterly. They told us they used this information to deliver care and treatment.

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). The most recent published results were 96.4% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets or exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the national average. For example, 91% of patients on the diabetes register had had a foot examination and risk classification within the preceding 12 months (national average 88%).
- Performance for mental health related indicators was similar to the national average. For example, 82% of patients diagnosed with dementia had had a face-to-face care review in the preceding 12 months (national average 84%).

There was no evidence of quality improvement including clinical audit.

- There had been three clinical audits conducted in the last two years. We found these audits were not full audits cycles. The provider could not evidence that as a result of the audits, improvements were made, implemented or monitored.
- The provider could not show evidence they had participation in accreditation or research.

Effective staffing

The practice could not demonstrate how the staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed administrative staff. This covered discussions on topics including health and safety and fire procedures.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. The learning needs of staff were not identified through systems of appraisals, meetings or reviews of practice development needs. Clinical staff had access to monthly CCG training meetings, but we saw no evidence of on-going support or one-to-one meetings or coaching and mentoring.
- Staff had completed online training on topics that included: safeguarding, fire safety awareness and confidentiality. The online training system had been installed in January 2016. We saw no evidence of training for non-clinical staff completed prior to this. We saw online training records for four members of administrative staff and found that they had completed on average 19 hours of online training between 5 and 10 March 2016. Some of the training that had been completed was not relevant to their roles. For example, we saw administrative staff had completed telephone triage and consultation training.
- Although all staff had received an appraisal within the last 12 months, the appraisal system was not effectively used to identify or discuss learning needs. Appraisals consisted of mainly staff self-evaluation with no evidence of management review of staff performance, personal or professional development. We saw evidence of completed appraisal documents from February 2016, however there was a lack of evidence of appraisals being carried out for staff prior to this.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training, which had included an assessment of competence. However not all staff had attended update training sessions for cervical screening. 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 CCG training meetings.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system.

- This included care plans, medical records and investigation and test results.
- We found a very large number of tasks for scans and x-rays on the providers list from December 2015, which had not been correctly filled. However, on review we found that appropriate action had been taken to address any concerns with patients. Fifteen out of the 20 reports we looked at had been actioned in the patient notes and appropriate contact or further action where necessary had been made. Five of the records had not required follow up with patients.

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 monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment.

- Not all GPs we spoke with had a comprehensive understanding of the Deprivation of Liberty Safeguards (DOLs) and had not had Mental Capacity Act 2005 training. (The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005 The safeguards are used to protect the rights of people who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted.)
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent and clinical staff used Gillick and Fraser guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the provider said the GP assessed the patient's capacity but there were no formal records of this.
- The process for seeking consent was not monitored through patient records audits.

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. Patients were signposted to the relevant service.
- Smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 82%, which was higher than the CCG average of 72% and the national average of 74%. The practice offered up to three telephone reminders for patients who did not attend for their cervical screening test. The practice could not demonstrate how they encouraged uptake of the screening programme by using information in different languages or for those with a learning disability but they ensured a female sample taker was available. The practice opportunistically encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 74% to 93% and five year olds from 55% to 73%.

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.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- 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 received 37 patient Care Quality Commission comment cards, 31 were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful and caring. Six comment cards highlighted concerns around difficulty in making urgent and routine appointments. Patients also referred to long waiting times, which could be up to 50 minutes.

We spoke with one new member of the patient participation group (PPG) and five patients. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 87% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 81% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 79% and the national average of 87%).
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and the national average of 95%).
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%).
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% 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 informed decisions about the choice of treatment available to them. Patient feedback from the comment cards we received was 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:

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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. There were no notices in the reception areas informing patients this service was available.
- There was a display in the waiting room on asthma and inhaler techniques for patients.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

There was a lack of patient information leaflets and notices in the patient waiting area and the practice told us that the waiting room had recently been redecorated. Staff told us they were working on making displays for the waiting area.

The practice's computer system alerted GPs if a patient was a carer. The practice had identified 24 patients as carers (0.4% of the practice list). The practice told us that this was not a true representation of the practice population and believed they had approximately 70 patients who were carers. The practice was identifying carers opportunistically and there was no clear process of recording this alert onto the computer system. We saw no evidence of written information or information on the practice website to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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), but we did not see evidence of the practice working with the CCG to secure improvements to services.

- There were longer appointments available for patients with a learning disability and other patients who requested them.
- We were told home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- We were told 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 and were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice had a 'no-walk-in policy', therefore all patients needed to make an appointment.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 9.00am to 11.30am every morning and 4.00pm to 6.30pm daily. There were no afternoon appointments on Wednesdays. The practice had extended hours at the following times between 6.30pm and 8.00pm Monday, Tuesday and Thursday and between 6.30pm and 7.00pm on Friday. During extended hours people could make appointments to see the nurse. Pre bookable appointments could only be booked up to one week in advance, and staff told us that 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 local and national averages.

- 86% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 83% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

What people told us on the day of inspection did not always align with the national GP patient survey findings. People told us on the day of the inspection that they found it difficult to make pre-bookable appointments when they needed them, especially those who worked during the day. They also reported it was difficult to get through to the practice phone line. Patients said that it was difficult to make an appointment with a named GP and they could wait up to 50 minutes at times when attending appointments.

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were not in line with recognised guidance and contractual obligations for GPs in England. Complaints were only acknowledged when given in writing.
- There was a designated responsible person who handled the clinical complaints in the practice and another person for management related complaints.
- We saw that information was available to help patients understand the complaints system such as a poster. Staff told us all complaints needed to be made in writing and verbal complaints were not accepted.

We looked at four complaints received in the last 12 months and found that two complaints were about negligence and were being managed by a legal team on behalf of the patients. We did not see evidence to show what, if any lessons were learnt from complaints or the action taken as a result to improve the quality of care. There was no evidence of any action, supervision, training or identified support for staff involved. We saw no evidence of correspondence with patients.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice staff did not know what the vision of the practice was.

- The practice had a mission statement but only the lead GP knew what it was. The mission statement was not displayed in the waiting areas and staff were not aware of it.
- The practice did not have a written strategy and supporting business plan to reflect the vision and values.

Governance arrangements

The practice lacked a clear governance framework to delivery good quality care.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Policies were implemented and were available to all staff. However, these did not always have the necessary practice specific details. Some policies required review and others had no indication of when a review was required.
- A comprehensive understanding of the performance of the practice was not always maintained across all staffing groups.
- While some audit and data collection was carried out, there was no programme in place for continuous clinical and internal auditing to be used to monitor quality and to make improvements.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not in place.
- There were no arrangements to monitor role specific staff training. When training had been completed there were no methods of checking staffs understanding. For example, two members of staff had had in-house chaperone training and had completed online training but did not understand where to stand when chaperoning.

Leadership and culture

Staff told us that the lead GP and practice manager were approachable and always took the time to listen to them.

The practice manager was not aware of and did not have 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). We saw no evidence that the providers were giving support training for staff on communicating with patients about notifiable safety incidents. The practice could not show evidence of having systems in place to ensure that when things went wrong with care and treatment that this was effectively communicated with people.

- The practice did not give affected people reasonable support, truthful information and a verbal and written apology
- The practice kept some written correspondence but did not keep written records of verbal interactions.

There was a leadership structure in place and staff told us that they felt supported by management. However:

- Staff told us the practice did not hold regular team meetings. There was no evidence to demonstrate that all staff were involved in discussions about how to run and improve the service delivered by the practice. Relevant information was shared ad-hoc with administrative staff. Clinical meeting were held monthly and these were attended by GPs, nurses and the practice manager.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported.

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

The practice sought patients' feedback in order to engage patients in the delivery of the service.

- The practice had not gathered feedback from patients through the patient participation group (PPG) as there were only a few members and the practice were in the process of recruiting.
- The practice carried out annual patient surveys. The last survey carried out in January 2015 had nine patient responses. The practice told us that the survey showed patients wanted appointment systems to improve. As a result the practice implemented a new telephone triaging appointment system for three months. Staff did

Are services well-led?

Inadequate

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

not believe the new appointment system helped and felt it doubled their work load and therefore the appointment system went back to the original system of pre-booked appointments.

- There was no evidence that the practice gathered feedback from staff. Staff appraisals had taken place but these were based on self-assessment with very limited comments added by the practice manager or the lead GP.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. The provider had failed to identify the risks associated with the lack of proper and safe management of medicines. The provider had not ensured that there was adequate infection control and prevention measures in place. The provider had failed to ensure that necessary pre-employment checks had been completed on staff. Clinical staff did not have knowledge of Mental Capacity Act 2005. The provider had not ensured the correct legal authorisation were in place required for staff to carry out their roles safely. The provider failed to risk assess staff needing a DBS check to carry out chaperoning duties. The provider failed to have systems in place to ensure people affected by significant events were informed of the actions or outcomes. This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	The provider did not have adequate systems or processes in place to ensure that risks were assessed, monitored, improved or mitigated The provider had not completed regular clinical audits to improve patient safety and outcomes. The provider did not ensure that all policies and procedures to govern activity were practice specific or always up to date. The provider did not have arrangements to monitor role specific staff training. When training had been completed there were no methods of checking staffs understanding. The provider had failed to seek and act on feedback from people who use services and did not use this to evaluate and improve services. The provider failed to have systems in place to ensure people affected by significant events were informed of the actions or outcomes. The provider had failed to escalate events to appropriate bodies when necessary. The provider did not have effective systems in place to securely monitor blank prescriptions. This was a breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The provider did not investigate and take necessary and proportionate action in response to any failures identified by the complaints or investigation. The provider did not have an effective system for identifying, receiving and recording complaints by service users. This was a breach of regulation 16(1)(2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.