

Dr Alec Yolomoni Kapenda

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?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Alec Yolomoni Kapenda on 5 July 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- The practice treated all patients as individuals and was responsive to personal need, including directing patients to appropriate social care as well as health care.
- Risks to patients were not always assessed and managed, for example no safety checks had been made for utilities such as gas and electricity and health and safety risk assessments had not been reviewed since 2011.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. The practice had received no formal written complaints in recent years, but was responsive to informal complaints.
- 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 implemented a policy that children were always seen without appointments to improve access for parents with concerns about their children's health.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour although continuity plans required updating to reflect the requirements.
- The practice had made improvements in some patient outcomes, such as prescribing and diabetes management, though audit was not used to continuously improve patient outcomes.
- We noted that the indemnity cover in place did not include the practice nurse; however this was addressed during the inspection.

We saw one area of outstanding practice:

The practice recognised that many older and vulnerable patients had become socially isolated and implemented individual solutions to support these patients. For example, some patients received telephone calls before holiday periods to offer support and encouragement; one patient had become a volunteer within the practice and in 2015 the practice also worked with the patient participation group to host a Christmas party which was attended by 30 – 40 older patients.

The areas where the provider must make improvement are:

- Emergency medicines and equipment must be risk assessed and a stock control system introduced to ensure they are always in date.
- Prescription pads must be stored securely, including reducing the quantity carried outside the practice.
- Update health and safety risk assessments to ensure all potential risks have been identified and mitigating actions taken, to include blind pull cords and undertaking legionella risk assessment.
- Implement a record system for recording nationally issued safety alerts and actions taken.
- Improve the quality of coding in patient medical records including demonstrating that diagnoses are recorded and that medical conditions have been adequately reviewed when medication reviews are undertaken.

The areas where the provider should make improvements are:

- Formalise quality improvement work and conduct regular clinical audits and re-audits to improve patient outcomes.
- Review and update procedures and guidance, including the business continuity plan to incorporate effective reporting under the Duty of Candour requirements.
- Formalise the review process for significant events to ensure that all learning has been implemented.
- Complete the work to introduce multi-disciplinary meetings and engage with the wider work to support patients who are terminally ill through collaborative working.
- Introduce a practice website to improve patient access to practice and wider health information.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

Requires improvement



- There was an effective system in place for reporting and recording significant events, although reviews were not consistently carried out to ensure all learning had been implemented.
- Patients were at risk of harm because not all risks had been identified and addressed. Although some recent health and safety risk assessments had been carried out, many risk assessments were dated 2011, and had not been reviewed. No safety checks had been carried out on gas or electrical equipment and not legionella risk assessment was in place.
- Blind pull cords had not been risk assessed.
- There was no risk assessment to determine what emergency medication was required. Limited medicines were available and one of these was out of date.
- There was no audit trail of blank prescriptions held by the GP and blank prescriptions were not stored securely.
- There was a fire safety risk assessment in place and fire safety checks and fire drills took place regularly.
- The practice was clean and hygienic and infection prevention control met requirements.
- The practice had been a high prescriber for some high risk medications, such as antibiotics and had made progress with reducing some of these according to Clinical Commissioning Group (CCG) prescribing data.
- Patient medication reviews had been carried out, although there was insufficient evidence that medical conditions were fully reviewed.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were in line with national and local averages. However, the data for 2014-2015 showed that some indicators had high 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).

Summary of findings

- For example, 100% of patients with atrial fibrillation who met the criteria were treated with appropriate medication to reduce the risk of heart failure and 85% of patients with hypertension had a recent blood pressure reading which was within a normal range.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Full clinical audits had not been carried out, though there was evidence of quality improvement in some areas. The practice was aware it had room to improve to demonstrate continuous quality improvement.
- Staff had the skills, knowledge and experience 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, and the practice planned to begin hosting multi-disciplinary meetings at the time of our visit.
- We noted that the practice nurse was not fully covered by the GP's indemnity insurance, although this was addressed during the inspection with full cover being arranged.
- Reviews of prescribed medication were taking place, although details recorded were minimal.
- The practice had been a high prescriber for some high risk medications, such as antibiotics and had made progress with reducing some of these according to Clinical Commissioning Group (CCG) prescribing data.
- Clinical diagnoses and information from other healthcare providers not consistently coded in patient medical records, the practice manager informed the inspection that this had been discussed with the GP and they hoped to access relevant training for the GP to improve this.
- A number of staff had been supported to undertake training and development.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example, 100% of patients said that it was generally easy to get through the practice by phone, which was higher than the national average of 73%. 91% of patients said that they were able to get an appointment the last time they wanted, which was also higher than the national average of 76%.

Good



Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice supported patients who had experienced a bereavement, attended funerals where appropriate and provided individual support for many patients to help them with health and social care needs.
- The practice had 23 patients coded as carers, 1.5% of the population and offered individual support to these patients. Carers were offered health checks.
- Staff also informed the inspection that they were cared for and supported and were highly motivated to care for patients.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice was aware of the diverse needs of the local population and reviewed these and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice worked with the community matron who provided additional care for patients aged 75 years or over and worked closely with the nursing team for patients in residential and care homes.
- 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. The practice had no formal written complaints for several years, although they explained how patient concerns were addressed responsively informally. The practice described how they approached areas of concern and were open and honest with patients who had been involved in incidents.
- The practice acted on suggestions from the patient participation group (PPG) to improve the facilities and services offered.

Good



Are services well-led?

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

Good



Summary of findings

- The practice had a clear mission 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 a number of policies and procedures to govern activity and held regular meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk, although the practice recognised that there were improvements required to reduce risks to patients and staff.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. Local policies required updating to reflect legislation on reporting requirements.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

Good



- 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.
- The practice worked with the community matron who cared for patients aged over 75 years. These patients were offered an assessment of their needs and ongoing support, including home visits for those who were housebound.
- The practice worked with the patient participation group in 2015 to host a Christmas party, which they invited older patients to. They believed that between 30 and 40 patients attended.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Four out of five indicators for patients with diabetes were above national average. For example, 91% of patients with diabetes had a blood pressure reading which was within a normal range, which was higher than the national average of 78%.
- 100% of patients with chronic obstructive pulmonary disease (COPD, a lung condition) had a full annual review documented in their records in the last 12 months, which was also higher than the national average of 90%.
- The practice was aware of areas it had to improve for patients with long term conditions and had a plan in place. Data shared by the practice for 2015-2016 showed an improvement.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

- Patients with COPD were encouraged to have a home rescue pack with advice on when they should use these medications.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- 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 relatively high for standard childhood immunisations for one and five year olds, though three out of five immunisations for two year olds were lower than averages.
- The practice informed parents that they did not need to make an appointment for children, simply bring the child in and they would be seen.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- 82% of eligible women had a cervical screening test in the previous five years, which was in line with the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- Sexual health screening was available within the practice.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working aged people.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice had no website, although on-line access to appointment booking and ordering prescriptions was available through the IT system.
- The practice offered electronic prescription services working with local pharmacies.

Good



Summary of findings

- Extended hours appointments were available in the practice on Tuesday evenings from 6.30pm until 7.30 pm, and patients also had access to evening appointments Monday to Friday and Saturday mornings at a practice nearby which Dr Kapenda worked collaboratively with.
- Telephone appointments were offered to people who could not attend the surgery in person.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of vulnerable people.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. These patients were given open access to the surgery and a direct telephone number for a clinical member of staff.
- Patients who were homeless were registered and directed to the local shelter which provided food and social support.
- The practice worked closely with the local substance misuse service.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Patients were encouraged to self refer to mental health and substance misuse teams locally.
- 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 information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice recognised individual vulnerable patients, and made contact with them before holiday periods to offer emotional and health care support.
- One patient who the practice had supported following a bereavement became a volunteer at the practice, this reduced their social isolation as well as helping them remain active.
- The practice invited older patients who were socially isolated to the Christmas party, although this had grown to include a wider range of older patients.
- The practice used easy read leaflets to assist consultations.

Good



Summary of findings

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health.

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was higher than the national average of 84%.
- 92% of patients with severe mental health conditions had a full review in the last 12 months, which was also higher than the 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.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016 and showed the practice was performing in line with or above local and national averages. A total of 379 survey forms were distributed and 80 were returned (21%). This represented 5.4% of the practice's patient list.

- 100% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 91% 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%.
- 91% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 72% 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 22 comment cards which were all positive about the standard of care received. The word which was used most on the cards was excellent, with patients all praising the small staff team and individuals for their care and empathy. One card said occasionally the GP appeared a little abrupt with younger patients, but that it was evident the GP cared.

We spoke with six patients and three members of the patient participation group who were also patients during the inspection. All nine patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Several patients gave examples of how they felt the GP and staff had identified health concerns which were addressed swiftly. Recent friends and family test results (FFT) were also positive, 95% of patients (19 responses) said they would recommend the surgery.

Areas for improvement

Action the service **MUST** take to improve

The areas where the provider must make improvement are:

- Emergency medicines and equipment must be risk assessed and a stock control system introduced to ensure they are always in date.
- Prescription pads must be stored securely, including reducing the quantity carried outside the practice.
- Update health and safety risk assessments to ensure all potential risks have been identified and mitigating actions taken, to include blind pull cords and undertaking legionella risk assessment.
- Implement a record system for recording nationally issued safety alerts and actions taken.
- Improve the quality of coding in patient medical records including demonstrating that diagnoses are recorded and that medical conditions have been adequately reviewed when medication reviews are undertaken.

Action the service **SHOULD** take to improve

The areas where the provider should make improvements are:

- Formalise quality improvement work and conduct regular clinical audits and re-audits to improve patient outcomes.
- Review and update procedures and guidance, including the business continuity plan to incorporate effective reporting under the Duty of Candour requirements.
- Formalise the review process for significant events to ensure that all learning has been implemented.
- Complete the work to introduce multi-disciplinary meetings and engage with the wider work to support patients who are terminally ill through collaborative working.
- Introduce a practice website to improve patient access to practice and wider health information.

Summary of findings

Outstanding practice

We saw one area of outstanding practice:

The practice recognised that many older and vulnerable patients had become socially isolated and implemented individual solutions to support these patients. For example, some patients received telephone calls before

holiday periods to offer support and encouragement; one patient had become a volunteer within the practice and in 2015 the practice also worked with the patient participation group to host a Christmas party which was attended by 30 – 40 older patients.

Dr Alec Yolomoni Kapenda

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist adviser, an Expert by Experience (someone who has knowledge of CQC methodology and has used GP services) and a second inspector.

Background to Dr Alec Yolomoni Kapenda

Dr Alec Yolomoni Kapenda provides primary health care services to 1472 patients in the industrial town of Accrington, East Lancashire under a General Medical Services (GMS) contract with NHS England.

Dr Kapenda is a sole GP provider and works with a small team, this includes a practice nurse who is also the practice manager and a support team of four administration staff. The building has been converted from a residential building and comprises a reception and waiting area downstairs with a storage room and consulting room. There is a patient toilet and baby change facility on the ground floor. Upstairs is a nurse treatment room, an office and a meeting room.

The practice is open Monday, Wednesday and Friday 8am until 6:30pm, Tuesdays from 8am until 7:30pm and Thursdays from 8am until 12:30pm. Appointments are available throughout the day, from 8:30am until 6:30pm each afternoon, with extended hours on Tuesday evenings. Cover is provided by a local practice on Thursday afternoons, and extended hours appointments are also available locally Monday to Friday 6:30pm to 8pm and Saturday mornings 9am until 12pm through a collaborative agreement with two other practices.

2011 census data shows a varied practice population with around 10-12% Asian patients and 80% white British. The practice has also seen an increase in Eastern European patients in the last few years. Age ranges are broadly in line with national averages though the practice has fewer than average 25 – 29 year old and over 50 year old patients. Male and female life expectancy is below East Lancashire Clinical Commissioning Group (CCG) and national averages, at 75 for men and 80 for women.

Information published by Public Health England rates the level of deprivation within the practice population as two on a scale of one to 10 (level one represents the highest levels of deprivation and level 10 the lowest). East Lancashire generally has a higher prevalence of Chronic Obstructive Pulmonary Disease (COPD, a disease of the lungs), smoking and smoking related ill-health, cancer, mental health and dementia than national averages.

OOH services provided by East Lancashire Medical Service Ltd.

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.

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 5 July 2016.

During this inspection visit we:

- Spoke with a range of staff including the GP, and manager/ practice nurse, the community matron and CCG pharmacist medicines manager, the deputy practice manager and reception staff.
- Spoke with patients who used the service and representatives of the patient group.
- Observed how staff interacted with patients and 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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available. The incident recording form required amending to support the recording of notifiable incidents under 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 evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice did not carry out analysis or trend review of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. Although the practice informed us that all alerts were acted upon, no audit trail of these was kept.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, although the inspection noted some concerns around medicines. The systems included:

- Arrangements were in place to safeguard children and vulnerable adults. 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. The principal GP was the safeguarding lead and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The GP was trained to child protection or child safeguarding level 3 and the nurse had also completed level 3 training.
- A notice in the waiting room advised patients that chaperones were available if required. The nurse acted as chaperone when requested although it was not recorded in the patient medical record when a chaperone had been used.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection prevention and control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Regular assessments of the premises were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, the washable seat covers had been obtained for patient chairs.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not ensure patients were kept safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Some work had taken place on routine medication audits in partnership with the CCG medicines manager. Improvements had been made to some high risk medication prescribing and the practice was aware of areas it still had for improvement including hypnotic items (hypnotics are used to treat sleep and anxiety disorders but can become addictive and have adverse side effects).
- Medication reviews and clinical coding were carried out by the GP. The inspection noted that no detailed information on diagnoses or medical conditions were included. The practice manager informed us that there was a plan to improve the system and for the GP to attend training in this.
- Blank prescription pads were not securely stored and there was no effective system in place to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed four personnel files and files for two locum GPs and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and

Are services safe?

the appropriate checks through the Disclosure and Barring Service (DBS check, which 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 noted that the personnel record for the most recently recruited member of staff was a summary sheet, not full record, although there was evidence of mandatory checks having been made.

Monitoring risks to patients

Risks to patients were not always assessed or well managed.

- Procedures for monitoring and managing risks to patient and staff safety were not fully compliant and some health and safety risk assessments had not been reviewed since 2011. The practice had up to date fire risk assessments and carried out regular fire drills. Electrical equipment was not checked to ensure the equipment was safe to use although clinical equipment was checked annually to ensure it was working properly. Gas safety checks had not been carried out and there was no legionella risk assessment or control regime in place, although heating and hot water were provided by a combination boiler which reduced potential risk of legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- We noted that blind pull cords had not been risk assessed in line with requirements. There were blinds in the waiting area which were easily accessible to young children.

- The practice staff team was small, though there were arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

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.
- All staff received annual basic life support training.
- The practice had limited emergency medicines, and we found one which was out of date. There was no stock control regime in place for emergency medication and no risk assessment in place to inform the decision to keep limited emergency drugs.
- The practice had a defibrillator available on the premises and oxygen with an adult mask. The child mask had been used and a replacement ordered at the time of our visit. A first aid kit and accident book were available. There was no nebuliser in place for children who were suffering from asthma attacks.
- 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. This had been reviewed following an incident outside the practice recently.

Are services effective?

(for example, treatment is effective)

Our findings

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 risk assessments, audits and random sample checks of patient records.

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 94.2% of the total number of points available.

We noted that clinical 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) had been higher than local and national averages for stroke and transient ischaemic attack (TIA, a mild stroke), chronic obstructive pulmonary disease (COPD, a lung condition) and diabetes. We discussed this with the practice during our visit and noted that the practice had recognised there were low numbers of patients and the practice shared QOF data from 2015-2016 which showed they had begun to address this through following up individual patients where appropriate.

This practice was not an outlier for any QOF clinical targets. Data from 2014-2015 showed:

- Performance for diabetes related indicators was better than the national average for four out of five indicators. For example, 91% of patients with diabetes had recent blood sugar tests and blood pressure readings which were within a normal range, which was above the national average of 78%.

- Performance for mental health related indicators was also better than national averages.
- 93% of patients with severe mental health conditions had a comprehensive care plan and review within the last 12 months, which was above the national average of 88% and 95% of these had a record of alcohol consumption, which was also above the national average of 90%.
- 79% of patients with asthma had a review within the last 12 months, which was above the national average of 75%.

There was limited evidence that clinical audit had been used consistently to improve patient outcomes.

- There had been two clinical audits completed in the last two years, neither of these were completed audits where the improvements made were implemented and monitored.
- However, the practice had been reviewing areas within QOF and following up to make continual improvements.
- The practice participated in the local medicines management scheme and a CCG pharmacist medicines manager worked with the GP to reduce prescribing of high risk medication.
- The practice had improved the care for diabetic patients following an ongoing audit of management of blood sugar levels for these patients.

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 such topics as 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. For example, the practice nurse had undertaken one module of training for management of patients with chronic obstructive pulmonary disease (COPD, a lung condition), although she had not completed diabetes training. The GP and nurse worked closely with the local specialist diabetes team to ensure that patients with diabetes were given good care.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of

Are services effective?

(for example, treatment is effective)

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.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- 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. The on-line learning system was currently unavailable and the practice did not have an alternative but informed us that the CCG was dealing with this.
- We noted that there was limited information in relation to reviews of patient medication, and discussed this with the team. We were informed that the GP had not had training in clinical coding.

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 intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The community matron completed comprehensive care plans for patients aged 75 years and older, although these were not accessed or reviewed by the GP routinely.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- However, some clinical information on diagnoses from other providers was not consistently coded into patient records. The practice manager informed the inspection that a recent discussion with the GP had taken place and they intended to arrange for him to attend training.

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. The practice had not engaged directly in multi-disciplinary meetings with other health and social care professionals, although the community matron had been attending these for patients aged 75 and older. The practice had a plan in place to commence regular meetings for patients who were terminally ill which they shared with us during the inspection.

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.
- The process for seeking consent was 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, carers, those at risk of developing a long-term condition and those requiring advice on their diet, requiring substance misuse support and those who were homeless. Patients were signposted to the relevant service.
- Smoking cessation was available with the practice nurse who could also refer to a local smoking cessation group if patients preferred. There was a new local scheme for healthy lifestyle and patients were encouraged to self-refer for lifestyle and weight loss advice.
- The practice's uptake for the cervical screening programme was 82% which was comparable to the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for

Are services effective?

(for example, treatment is effective)

their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. 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. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. National cancer information network data published in March 2015 showed that 55% of eligible female patients had attended breast cancer screening which was lower than the CCG average of 68% and national average of 72%. The practice followed patients up who had not attended national cancer or abdominal aortic aneurism screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 60% to 96% and five year olds from 92% to 100%. We discussed with the practice the screening results for two year olds which were generally lower than CCG averages and they informed us there had been a data quality issue which was being resolved and that current figures for childhood immunisations were 90%.

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

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very 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.

All of the 22 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. One card said that occasionally the GP could be abrupt with younger patients, but was caring.

We spoke with six patients and three members of the patient participation group (PPG). They also 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 was below average for some satisfaction scores on consultations with GPs and nurses. For example:

- 78% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 87% of patients said the GP gave them enough time which was in line with the CCG and national averages of 87%.
- 84% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.

- 76% 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%.
- 94% 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%.
- 96% 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 an informed decision 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. Most results were generally in line with local and national averages. For example:

- 79% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%.
- 66% 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%.
- 90% 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 survey results did not align with the responses and input from patients we spoke with during the inspection.

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. The practice nurse spoke French and the GP Nsenga. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

Are services caring?

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. There was no practice website [JM1] which restricted access to information for patients.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 23 patients as carers (1.5% of the practice list). Written information was available to direct carers to the various avenues of support available to them, the practice had a carers' notice board and offered carers health checks and influenza immunisation.

Staff told us that if families had suffered bereavement, they offered support to meet the family's needs by giving them advice on how to find a support service. The practice nurse/ manager attended funerals where appropriate, and one patient became a volunteer at the practice following the death of their partner, which reduced their social isolation and kept them active and engaged.

The practice recognised a number of individual patients who required social and emotional support, and contacted them to offer advice and encouragement, for example, prior to bank holiday periods which some found difficult to cope with.

[JM1] Should this be a SHOULD?

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) to secure improvements to services where these were identified. This included engaging with the community matron who provided services for patients aged 75 years and older. The practice informed the inspection team that it was only recently they had begun collaborating effectively with other practices and partner organisations in the area.

- The practice offered extended hours appointments on Tuesday evenings and patients could also access appointments Monday to and Friday 6.30pm until 8pm and Saturday mornings 9am until 12pm at a nearby practice through a collaborative approach to offering extended hours access.
- There were longer appointments available for patients with a learning disability.
- Vulnerable patients were given immediate access to the practice.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities and translation services available. There was a chair lift to the first floor, although most consultations took place on the ground floor.
- The practice worked with the local substance misuse service and also offered support to homeless patients if they requested health care services.
- The practice supported around 20 patients in a local care home and worked closely with the advanced nurse practitioner scheme run by the CCG to support patients living in nursing and residential care homes.
- The practice was aware of vulnerable patients and contacted some patients prior to holiday periods to offer emotional support as well as health care advice and encouragement.

- The practice had implemented a policy that children did not require appointments and parents were advised to bring them in so they could be seen by the GP or nurse immediately.
- Patients who could not attend during normal working hours were offered appointments to suit their needs and telephone appointments, triage and advice was available if required.

Access to the service

The practice was open between 8am and 6:30pm Monday, Wednesday and Friday, 8am until 7pm on Tuesdays and 8am until 12:30pm on Thursdays. Appointments were from 9:30am to 11:30 every morning and 3pm to 5:30 daily. Extended hours appointments were offered between 6:30pm and 7:30pm on Tuesday evenings. Extended hours appointments were also available Monday to Friday 6.30pm until 8pm and Saturday mornings 9am until 12pm through a collaborative scheme with two other local practices. In addition to pre-bookable appointments that could be booked up to six 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 above local and national averages.

- 91% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 100% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

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

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.

Are services responsive to people's needs?

(for example, to feedback?)

- We saw that information was available to help patients understand the complaints system with a leaflet and information in the waiting area although the practice did not have a website with patient information.

The practice had not received any formal complaints for a number of years, so we were unable to view how these were handled. We did review informal complaints which

were recorded in the reception diary and dealt with promptly by all staff. The practice could describe the process and share information on how complaints would be dealt with. They were also able to share with us occasions when lessons had been learned from significant events and how patients were given appropriate information and apologies.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice mission statement was “we are committed to providing high quality health care to all patients, through a well-trained and motivated primary health care team within a friendly and caring environment”. Staff we spoke to related to the values.

A number of strategic developments had taken place over recent years and the practice could describe plans for improving services in the future. There was an awareness of strategic planning, though this was not written in any formal documents.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. The team was small and the practice manager/ nurse was responsible for day to day management and operation of the practice, working closely with the principal GP.

- The staffing structure was clear and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff, although some required updating.
- A comprehensive understanding of the performance of the practice was maintained.
- Limited clinical audit had been undertaken and the practice acknowledged they had further work to do in this area.
- Arrangements were not consistently adequate to identify, record and manage risks and further work was required to ensure that clinical coding in patient records was accurate and covered all information relating to diagnoses and reviews of medical conditions.
- Positive events as well as significant events were recorded and reviewed and the practice discussed these at staff meetings to share learning.

Leadership and culture

On the day of inspection the principal GP and practice manager demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

They told us they prioritised safe, high quality and compassionate care, and recognised areas which required improvement and assured the inspection team these would be addressed promptly. Staff told us the partners were approachable and always took the time to listen to all members of staff. Two staff shared examples of how the principal GP and practice manager had supported them during difficult personal circumstances.

The provider was aware of the requirements of the duty of candour, but needed to update policies to reflect this (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 principal GP 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 appropriate support, truthful information and a verbal and written apology.
- The practice kept written records of verbal complaints, although they had not received any written correspondence.

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

- Staff told us the practice held regular team meetings.
- 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. All staff were involved in discussions about how to run and develop the practice, and the principal GP and manager encouraged all members of staff to identify opportunities to improve the service delivered by 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. It proactively sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Good 

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice had replaced carpets after suggestions from the PPG, and also updated notice boards.
- The practice had gathered feedback from staff through one to one meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement throughout the practice. The practice shared information and action plans for ongoing improvement with the inspection team.

The practice team had begun engaging with local initiatives, the community matron and working collaboratively with local practices but informed the inspection this was work in progress.

The practice recognised that the patient population presented a variety of complex problems and were working to ensure these patients were given the right care.

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 Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Patients were being put at risk due to inadequate risk assessment and mitigatory actions which included:• Gas and electrical safety checks had not been carried out.• There was no risk assessment or stock control system for emergency drugs and equipment, and some emergency drugs were out of date.• Prescription pads were not stored securely and there was no adequate audit trail of individual prescriptions held by the GP.• Blind pull cords were not risk assessed.• Health and safety risk assessments had not been reviewed since 2011.• There was no audit trail to evidence actions taken in response to nationally issued safety alerts.• Clinical coding in patient medical records did not demonstrate that diagnoses were recorded and medical conditions were adequately reviewed when medication reviews were undertaken. <p>This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>