Red Suite

Quality Report

Healthy Living Centre
Balmoral Gardens
Gillingham
Kent. ME7 4PN.
Tel: 01634 334937
Website:

Date of inspection visit: 11 June 2015
Date of publication: 05/11/2015

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	Inadequate
Are services safe?	Requires improvement
Are services effective?	Inadequate
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 Red Suite on 11 June 2015. Overall the practice is rated as inadequate.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and addressed.
- Staffing levels had not always been maintained and kept under review to ensure the needs of patients were appropriately managed and met, including keeping administrative tasks up-to-date.
- Risks to patients were assessed, although systems were not always implemented to manage identified risks, including recruitment checks, and safety audits in relation to infection control.
- Clinical audits had been carried out to help drive and improve patient outcomes.
- There was insufficient assurance to demonstrate that patients' health care needs were effectively managed, as there was limited data to demonstrate how the practice managed, supported and met the on-going care and treatment needs of patients.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- Information about services was available and easy to understand, although the practice complaints procedure had not been displayed within the practice.
- Urgent appointments were usually available on the day they were requested. Patients said that routine appointments were usually easy to get with the GPs, although they sometimes had to wait beyond their appointment times.
- The practice had a number of policies and procedures to govern activity and these were mostly in-date.
- The practice did not have a patient participation group (PPG), although feedback from patients was sought in other ways.

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure the governance arrangements include systems and processes to audit and monitor the quality and safety of the services provided, including systems to demonstrate and provide assurance of how patients' health care needs are managed, supported and met.
- Ensure the governance arrangements include audits to monitor staff training, infection control, and keeping the business continuity plan updated.
- Ensure the governance arrangements include a system to maintain and deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff, to effectively support and meet the needs of patients, including all clinical and administrative tasks.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons learned from incidents were shared with staff to support improvement. Risks to patients who used services were assessed and monitored, although there were areas where risks had not been addressed. For example, recruitment checks when staff were employed, some areas of staff training, as well as some concerns in relation to infection control.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements must be made. There were concerns in relation to how the practice monitored its performance and there was no evidence that the practice was comparing its performance to others; either locally or nationally. The data that was available showed that patient outcomes were below average for the locality. There was evidence of completed clinical audit cycles and these were used to improve patient outcomes in some specific clinical areas.

There were concerns in relation to the changes made to the nursing staff at the practice within the last year. There were insufficient clinical nursing hours to undertake patient checks and health care reviews, especially for those patients with long-term / complex conditions. The practice were aware of this and planned to recruit a health care assistant.

Multi-disciplinary working was taking place but was generally informal and record keeping was limited or absent.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. It reviewed the needs of its local population and engaged with the local clinical commissioning group (CCG) to secure

Summary of findings

improvements to services where these were identified. Patients said they usually found it easy to make an appointment with a named GP, with urgent appointments available the same day, although appointments with the nurse were not readily available. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available in the practice leaflet, although the procedure was not readily to hand and displayed within the practice. Evidence showed that the practice responded to issues raised and learning from complaints was shared with staff.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. There was a leadership structure and most staff felt supported by management and knew who to approach with concerns or issues. However, some staff were unclear about their roles and responsibilities in relation to the administrative tasks and the workload demands within the practice. The management had acknowledged there were staff shortages in both clinical and administrative areas, but a systematic approach had not been used to determine the overall number of staff and range of skills required to meet and support the needs of patients. This included administrative tasks that had not been kept up-to-date.

The management did not have a system to demonstrate and provide assurance that the health care needs of patients were effectively managed and met, and that its clinical performance was monitored. Systems were not always used to audit and monitor quality and safety, including staff training, infection control and business continuity. The practice had a number of policies and procedures to govern activity and most of these had been reviewed. The practice had sought feedback from patients, although a patient participation group (PPG) had not been established. All staff had received regular performance reviews and attended staff meetings.

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 practice is rated as inadequate for the care of older people. The concerns that led to the practice requiring improvement for providing safe and responsive services and inadequate for providing effective and well-led services, applied to this population group. The practice offered proactive, personalised care to meet the needs of the older people in its patient population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and longer appointments for those with enhanced needs. All of these patients had a named GP.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The concerns that led to the practice requiring improvement for providing safe and responsive services and inadequate for providing effective and well-led services, applied to this population group. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The concerns that led to the practice requiring improvement for providing safe and responsive services and inadequate for providing effective and well-led services, applied to this population group. There were systems to identify children living in disadvantaged circumstances and who were at risk. Children were seen on the same day if appointments were requested. Immunisation rates were mostly below the local averages for the standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people (including those recently retired and students). The concerns

Summary of findings

that led to the practice requiring improvement for providing safe and responsive services and inadequate for providing effective and well-led services, applied to this population group. 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 and flexible. The practice offered online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The concerns that led to the practice requiring improvement for providing safe and responsive services and inadequate for providing effective and well-led services, applied to this population group. The practice worked with multi-disciplinary teams in the case management of vulnerable people. Information was available 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.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The concerns that led to the practice requiring improvement for providing safe and responsive services and inadequate for providing effective and well-led services, applied to this population group. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. Information was available for patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our inspection. The majority told us they were satisfied with the care provided, that the practice was caring and understanding of their needs, and that staff were helpful, and treated them with dignity and respect.

Patients told us they had no concerns about the cleanliness of the practice and that they always felt safe. They said their children were treated and spoken to in an age-appropriate way by the GPs, who involved them and considered their views when offering treatments.

Patients told us the appointments system generally worked well and they were able to get same day appointments if urgent. The majority of patients said they always had enough time with the GPs and nurse to discuss their care and treatment thoroughly, they never felt rushed and that they felt involved in decisions about their care.

Patients had completed comment cards prior to our inspection, to tell us what they thought about the practice. We received 42 completed cards, the majority contained very positive comments. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Only four comment cards contained less positive comments, and these mainly related to the difficulty in getting through to the practice on the telephone in the mornings to book appointments.

Information from the 2014 national patient survey showed mixed results when compared to other local practices. The practice had been rated highly in some areas. For example, 90% of respondents said the last nurse they saw or spoke with was good at involving them in decisions about their care, compared to the local average of 85%. When asked the same question in relation to GPs, the practice was rated less well, with 58% of respondents in agreement, compared to the local average of 74%.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure the governance arrangements include systems and processes to audit and monitor the quality and safety of the services provided, including systems to demonstrate and provide assurance of how patients' health care needs are managed, supported and met.
- Ensure the governance arrangements include audits to monitor staff training, infection control, and keeping the business continuity plan updated.
- Ensure the governance arrangements include a system to maintain and deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff, to effectively support and meet the needs of patients, including all clinical and administrative tasks.

Red Suite

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 advisor and a practice manager specialist advisor.

Background to Red Suite

The practice offers appointments from 9am to 12.30pm and from 2pm to 6pm Monday to Friday and reception staff are available to take telephone calls from patients throughout the day from 8am. It operates extended opening hours until 9pm on Monday evenings. The practice is situated in the town of Gillingham in the Medway area of Kent and provides a service to approximately 5,100 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing staff. The practice has more patients registered under the age of 4 years than both the local and national averages. There are more patients registered between the ages of 20 and 30 years than the national average. The number of patients recognised as suffering deprivation for this practice, including income deprivation, is higher than the local and national averages.

The practice has three male GP partners, who employ a part-time female practice nurse. There are a number of administration staff, including a senior administrator / secretary.

The practice does not provide out of hours services to its patients and there are arrangements with another provider (MedOCC) to deliver services to patients when the practice is closed. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to the local community.

Services are delivered from:

Red Suite

Healthy Living Centre

Balmoral Gardens

Gillingham

Kent. ME7 4PN

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not received a comprehensive inspection before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to

Detailed findings

share what they knew. We carried out an announced visit on 11 June 2015. During our visit we spoke with a range of staff, including the three GP partners, two administration staff and the senior administrator / secretary. We spoke with patients who used the services and reviewed comment cards that patients had completed to share their views about the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents.

We reviewed safety records and incident reports for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. For example, an incident concerning the theft of a prescription form had been recorded, investigated and actions taken to help avoid a similar incident happening again.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events and we reviewed records of significant events that had occurred during the last year. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including reception and administrative staff, knew how to raise an issue for consideration at staff meetings and said they felt encouraged to do so.

A senior member of staff was responsible for managing all significant events and we saw the system used to monitor these. We tracked three incidents and saw records were completed in a timely manner and that actions were taken as a result. For example, a change to the administrative system had been made to check that patient referrals for hospital appointments were safely received, following a delay when an urgent referral had been made. Records showed that where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated and monitored by a senior member of staff within the practice. There was a system to help ensure that all safety alerts were seen and actions taken by relevant staff, including drug alerts and medical device alerts.

Reliable safety systems and processes including safeguarding

The practice had systems and arrangements to manage risks to vulnerable children, young people and adults who used the services. There was a policy for safeguarding children and vulnerable adults which clearly set out the procedures for staff guidance and contact information for referring concerns to external authorities. The policy was available to all staff on the practice computer, as well as in a hard copy file and reflected the requirements of the NHS and social services safeguarding protocols.

There was a lead GP for safeguarding, who had received the necessary training to fulfil their role in managing safeguarding issues and concerns within the practice. The staff we spoke with were all knowledgeable in how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies. Training records demonstrated that all staff had undertaken vulnerable adults and children's safeguarding training, with the exception of one member of staff.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. Staff liaised with relevant agencies, including the health visitor and social services to share information in relation to concerns that were identified within the practice.

The practice had a chaperone policy. A chaperone is a person who accompanies a patient when they have an examination and we saw that the practice policy set out the arrangements for those patients who wished to have a chaperone. Patients were made aware that they could request a chaperone, and details were displayed within the practice. Administration staff undertook chaperone duties and had received training in relation to this. The practice had not obtained criminal record checks via the Disclosure and Barring Service (DBS) for these staff, although risk assessments had been completed to consider potential risks to patients. (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).

Medicines management

Requires improvement

Are services safe?

We checked medicines kept at the practice and found they were stored securely and were only accessible to authorised staff. There were arrangements for ensuring that medicines were kept at the required temperatures, and staff described the action they would take in the event of a potential failure. Daily records of temperature checks were kept for refrigerators used to store medicines.

There were processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw up-to-date sets of PGDs that had been signed by the practice GPs. The nurse had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and were tracked through the practice and kept securely at all times.

The practice had liaised and met regularly with the area medicines management team in relation to medicines prescribing. The team supported the practice in reviewing prescribing protocols and initiating audits in the prescribing of certain medicines.

Cleanliness and infection control

The practice was clean, tidy and treatment rooms were uncluttered. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow. For example, the management of sharps and clinical and hazardous waste.

Personal protective equipment including disposable gloves and coverings were available and notices about hand hygiene techniques were displayed in staff and patient toilets. Anti-bacterial hand wash was available in the reception area and in appropriate places throughout the practice for patients to use.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. Domestic and clinical waste products were segregated and clinical waste was stored appropriately and collected by a registered waste disposal company.

Staff we spoke with were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control and there was a designated lead member of staff, who had received appropriate training to help ensure they were clear about their responsibilities. However, an audit had not been undertaken in the last year to identify any risks associated with infection control. Training records showed that not all staff had undertaken infection control training, for example, administration staff.

Cleaning schedules and records were kept that identified the cleaning activity undertaken on a daily, weekly and monthly basis and a system was used to manage the cleaning products and equipment.

The practice had considered the risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings) and a risk assessment had been completed and regular checks of the water systems were routinely undertaken.

Equipment

Staff told us that equipment used in the practice was routinely checked and said they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and records confirmed this, for example, records to demonstrate that portable electrical equipment had been tested.

Staffing and recruitment

Records showed that recruitment checks had not always been undertaken when employing staff. For example, a nurse had been employed by the practice in November 2014 and the staff file did not contain any documented references and photographic identification. A criminal record check through the Disclosure and Barring Service (DBS) had not been undertaken by the practice, although a DBS check was available from a previous employer. Professional registration checks had been undertaken for GPs and nursing staff.

Requires improvement

Are services safe?

The GPs told us that there had been a shortage of nursing hours in recent months and that they planned to recruit additional nursing staff. They also said there had been difficulties in managing some of the administration duties. There was a rota system to help ensure that enough administrative staff were on duty and there were arrangements for members of staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice, although they said there was sometimes pressure in completing all of the administrative tasks.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. There was a health and safety policy, including procedures and information for staff guidance, such as fire safety, with information displayed to show named members of staff who were designated fire safety marshals. There was a system governing security of the practice, for example, visitors were required to sign in and out using the dedicated book in reception. There were security locks on doors leading to staff areas, to prevent unauthorised access.

Staff we spoke with told us they used systems to identify and respond to changing risks to patients, including deteriorating health and well-being. Emergency referrals were made for patients who had experienced a sudden deterioration or urgent health problem. For example, patients experiencing a mental health crisis were supported to access emergency care and treatment from specialist mental health teams.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff, with the exception of one member of staff, had received training in basic life support and information was displayed for staff guidance in dealing with emergency situations and how to respond. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew where they were kept. There were processes to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a fire risk assessment that included actions required to maintain fire safety and regular checks of the premises had been undertaken. Records showed that most staff had received fire safety training and some staff had received additional fire marshal safety training.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, interruption to utilities, or unavailability of the premises. However, this had not been kept up-to-date with information relating to staff contact details.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE). Assessments of patients' needs were completed in line with these guidelines, using diagnostic tools available on the computer to access the most up-to-date documents.

The practice engaged with the area clinical commissioning group (CCG), mainly through practice management meetings and the GPs met with other practices in the local area on a monthly basis. Local referral pathways were used in areas such as cardiology, and patients we spoke with confirmed they were referred to other services or to hospital by the practice.

We reviewed data for the practice's performance for prescribing, which showed that the practice was in line with similar practices for national prescribing indicators, including anti-inflammatory and antibiotic medicines. The practice met regularly with a prescribing advisor from the CCG to help ensure updated guidance was followed.

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

Management, monitoring and improving outcomes for people

The practice kept registers to identify patients with specific conditions / diagnosis, for example, patients with long-term / chronic conditions including asthma, heart disease, and diabetes. Clinics were held by the practice nurse to manage their on-going care and treatment. Information from the practice registers was collated and linked to the Quality Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

We reviewed the information from the QOF data that was available for the practice. We found that there was limited data to demonstrate how the practice maintained and managed the health care needs of patients with long-term / complex conditions. For example, data was not available to demonstrate how the practice managed the on-going care needs of patients with diabetes or for those patients experiencing mental health problems. The overall recorded achievement of the total QOF target was 40% for 2014, which was significantly below the national average of 94%. Some improvement had been noted in the current year and data showed an overall 50% achievement of the total QOF target for 2015.

In our discussions with the GPs and the senior administrator, we were told that the practice had recognised that this was an area requiring improvement. They said there had been staffing difficulties in managing the QOF process for some time and there was not a designated member of staff to oversee the administration of the system. We were also told that the data entered into the data-base may not be accurate as there was a general lack of understanding in using the system. The practice was therefore unable to evidence or provide assurance that they were meeting and supporting the on-going health care needs of patients, particularly those with long-term / complex conditions. This was supported by evidence seen in the QOF data supplied by the practice to the clinical commissioning group (CCG) in relation to their QOF outcomes.

The GPs said that there had been difficulties in providing sufficient clinical nursing hours to undertake patient checks and reviews. We were told and records confirmed, that two part-time practice nurses working a total of 60 hours each week had retired in the last year and they had been replaced with one part-time practice nurse, who worked 25 hours each week. This had reduced the available clinical sessions in the practice in the last year. We looked at the available appointments with the nurse and found they were fully booked for the next three weeks. The practice was therefore unable to demonstrate that sufficient clinical nursing hours were available to effectively support the care and treatment needs of patients, particularly those with long-term / complex needs who required on-going checks and reviews of their care.

The GPs told us that they were about to recruit a health care assistant to work 30 hours each week and possibly an additional practice nurse to increase the clinical sessions

available to patients. They also planned to increase the administration staff to include a designated member of staff to manage the QOF process, to improve how data was collated and recorded.

We saw minutes of practice meetings where these issues had been discussed amongst the GP partners and the senior administrator. The minutes recorded that the GP partners acknowledged improvements were required in relation to the available clinical sessions and that the practice was in the process of recruiting a health care assistant and that interview dates were confirmed. It was also recorded that improvements to the process used for QOF reporting were required as this was having a negative impact on the performance indicators for the practice. For example, the minutes contained a list of issues in relation to the entries in the data-base and indicated that on many occasions, this had been incorrectly coded or information was missing.

All patients over the age of 75 had a named GP who was responsible for their care and treatment. Care plans had been implemented to support and manage the health care needs of patients with complex needs.

The practice had a system for undertaking clinical audits. We looked at three audits undertaken in the last year, including an audit that had been generated from prescribing guidelines. This was carried out to check that a specific type of medicine was appropriately prescribed and that blood tests were routinely undertaken to monitor the required dosage. The practice had gathered information from the patient records and reviewed the results. A re-audit had been undertaken to check that on-going improvements to prescribing practice had been maintained. Other audits included a re-audit each year for minor surgical procedures, as well as an audit to check that appropriate risk indicators were used in relation to a specific health condition.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and the computer system provided an alert for those patients who required a medicines review.

Effective staffing

The practice staff included GPs, a nurse, and administration staff, although there were some administrative functions that did not have designated members of staff to undertake specific tasks. For example, the collation of data to enter into the QOF system. The practice had also identified that there was a shortage of nursing hours to undertake clinical checks and reviews. The training records examined showed that all staff, with the exception of one member of staff, had attended mandatory training, such as basic life support and safeguarding. The GPs and nurse had completed specialist clinical training appropriate to their roles, for example, asthma, heart disease and updates in cervical cytology. We saw that staff had job descriptions outlining their roles.

Records confirmed that staff received annual appraisals. The staff we spoke with felt that the appraisal process had been beneficial and had helped them to identify training needs and provided an opportunity to discuss any problems with their manager.

All GPs were up to date with their annual continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Working with colleagues and other services

The practice worked and liaised with other agencies and health care professionals to discuss and review patient care, for example, with the palliative care team, specialist community nurses, and specialist hospice nurses. GPs said that multi-disciplinary meetings were not routinely held by the practice, although there were systems to communicate with other agencies about specific patients when required.

A GP from the practice undertook bi-weekly visits to a local care home to support older patients registered with the practice and to review the support they required from other health care professionals, for example social services.

The practice received blood test results, x-ray results, and letters from the local hospital (including discharge summaries), out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures for staff to follow in relation to passing information on, as well as reading and acting on any issues arising from communications with other care providers on

Inadequate

Are services effective?

(for example, treatment is effective)

the day that they were received. The GP who saw these documents and results was responsible for the action required and the staff we spoke with felt the system worked well.

Information sharing

There were systems to help ensure that patient information was shared with other service providers, including hospital services. There was a system to refer patients to other services, including the 'Choose and Book' referral system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). The practice had a process to check that referrals had been received and acted on.

The practice had systems to provide staff with the information they needed. An electronic patient record system was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system and told us the system worked well. The system enabled scanned paper communications, such as those from hospital, to be saved in the patients' electronic records. Historical patient records in paper form had been received by the practice, which required summarising into the computerised patient records system. We saw that this task had not been kept up-to-date, as there was a six month backlog of paper records waiting to be summarised and the information added into the computerised record.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how consent should be recorded.

Although staff had not received training in the Mental Capacity Act 2005, they were aware of their responsibilities in supporting patients who may lack the capacity to make decisions in relation to consent. The patient records system indicated whether a carer or advocate was available to attend appointments with patients who required additional support.

Health promotion and prevention

The practice nurse conducted various clinics and promoted healthy lifestyle choices when supporting patients with long-term conditions such as asthma and coronary heart disease. The practice also kept a register of patients who had a learning disability and promoted / encouraged annual health checks for these patients.

All new patients were offered a consultation with the practice nurse to assess their health care needs within two weeks of registering at the practice, to identify any concerns or risk factors, that would then be referred to the GPs. The practice also offered NHS health checks to all patients aged 40-75 and health care issues or concerns were followed-up by the GPs.

We saw a range of information leaflets and posters in the waiting area for patients, informing them about the services offered by the practice and promoting healthy lifestyles, for example, smoking cessation and weight loss programmes. Information about how to access other health care services was also displayed to help patients access the services they needed, for example, support groups for older people including details about memory clinics.

The practice carried out a full range of immunisations for children in line with national guidelines. Performance on childhood vaccinations varied and the available data showed that in most areas, childhood immunisation indicators were below the local averages. For example, the immunisation rate for the MMR vaccination was 87%, compared to the local average of 93%. There were some areas where the indicators were above local averages, for example, the 12 month meningitis vaccination rate was 98% compared to the local average of 96%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice in relation to patient satisfaction. This included information from the national patient survey undertaken in 2014 and the results of questionnaires completed by patients and collated by the practice. The results showed that patients felt they were generally treated well, although there were some mixed results.

Information from the national patient survey showed that patients had generally rated the practice either in line or below other local practices in some areas. For example, the data showed that 73% of respondents said that the GP they last saw or spoke with was good at listening to them, compared to the local average of 81%. However, in other areas the practice had been rated well compared to other local practices. For example, 68% of respondents said that they were usually able to see or speak to their preferred GP, compared to the local average of 59%.

We spoke with seven patients on the day of our inspection. The majority told us they were satisfied with the care provided and that the practice was caring and understanding of their needs. They also told us the staff were helpful, and treated them with dignity and respect. Patients told us that their children were treated and spoken to in an age-appropriate way by the GPs, who involved them and considered their views when offering treatments. We observed that reception staff were welcoming to patients, were respectful in their manner and showed a willingness to help and support them with their requests.

Patients had completed comment cards prior to our inspection, to tell us what they thought about the practice. We received 42 completed cards, the majority contained very positive comments. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Only four comment cards contained less positive comments, and these mainly related to the difficulty in getting through to the practice on the telephone in the mornings to book appointments.

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

The practice had a confidentiality policy, which provided guidance for staff in how to protect patients' confidentiality and personal information. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality and described how they followed the policy in practice. Staff had signed confidentiality agreements to confirm their awareness to the contents of the policy. A notice was displayed to inform patients they could request a room for private conversations with staff if they wished.

Care planning and involvement in decisions about care and treatment

The patient survey information showed there had been a generally positive response from patients to questions about their involvement in planning and making decisions in relation to their care. For example, data from the national patient survey showed that 90% of respondents said that nurses were good at involving them in decisions about their care, compared to the local average of 85%. However, the results were less positive in relation to GPs, as 58% of respondents said that GPs were good at involving them in decisions about their care, compared to the local average of 74%.

When we spoke with patients, the majority told us they felt involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. They said GPs and nurses took the time to listen and explained all the treatment options and that they felt included in their consultations. Data from the national patient survey showed that 88% of respondents felt that nurses were good at explaining tests and treatments, which was in line with the local average. Patients told us they felt able to ask questions and were not rushed during appointments. Patient feedback from the comment cards we received was very positive in this respect and was consistent with the more positive survey results.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

We observed that staff were supportive in their manner and approach towards patients. Patients told us that staff gave them the help they needed and that they felt able to discuss any concerns or worries they had.

Patient information leaflets, posters and notices were displayed that provided contact details for specialist groups offering emotional and confidential support to patients and carers, for example, counselling services in the local area. The practice had also developed a protocol to support patients who had suffered bereavement and referred patients to a specialist bereavement support service. The practice's electronic patient records system alerted GPs if a patient was also a carer. There was a range of information available for carers to help ensure they understood the various avenues of support available to them.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The staff we spoke with explained that a range of services were available to support and meet the needs of different patient population groups and that there were systems to identify patients' needs and refer them to other services and support if required. For example, referring patients with mental health needs to specialist groups who provided counselling support services. The practice GPs were flexible in seeing patients with mental health problems and offered 'open access' to those who were experiencing difficulties and at risk of self-harm. Meetings with other health care professionals were also arranged to provide additional support where necessary, for example, with the community psychiatrist and social services.

We observed reception staff making appointments for patients and they were helpful in accommodating patients' wishes wherever possible. They found times to suit patients' working arrangements and if this was not possible, looked for other convenient times.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. The practice did not have a patient participation group (PPG), although we were told this was planned. In the absence of a PPG, the practice had taken account of the views of patients from other sources, including the NHS friends and family test questionnaires, comments, complaints and general feedback. This had resulted in some changes to the way services were delivered, including a review of how appointments were offered and the practice had considered ways of making telephone access easier for patients, particularly in the mornings.

Tackling inequity and promoting equality

The practice was located in purpose-built premises that met the needs of patients with disabilities. Services were provided on the first floor of the building and there was a lift to provide access for those patients who had difficulty in using the stairs. The waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities. Interpretation services were available by arrangement for patients who did not speak English. There were car parking facilities with disabled parking areas close to the building.

Staff told us that they would not refuse access to services to patients who were homeless. They sometimes had patients coming to the practice who were homeless and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records and this was used to alert staff to patients who may need to be seen urgently.

Access to the service

The practice offered appointments from 9am to 12.30pm and from 2pm to 6pm Monday to Friday and reception staff were available to take telephone calls from patients throughout the day from 8am. The practice operated extended opening hours until 9pm on Monday evenings, to provide flexibility for working patients outside of core working hours and school hours for children. Outside of these hours, patients were requested to contact the 'out of hours' service if urgent medical treatment was required.

The practice offered a mix of pre-bookable and 'book-on-the-day' GP appointments, including flexibility to provide urgent or emergency appointments for patients to be seen on the same day. We looked at the available appointments and saw that whilst there was sufficient flexibility to provide appointments with the GPs, appointments with the nurse were fully booked for the next three weeks.

Patients could book an appointment by telephone, in person or online. Home visits were arranged for those who found it difficult to attend the practice, for example, older patients who were housebound. Longer appointments were available for patients who needed them, for example, if they had long-term conditions or complex health care needs.

Patients we spoke with expressed confidence that urgent problems or medical emergencies would be dealt with promptly, that staff knew how to prioritise appointments for them and that they would be seen the same day. Feedback we received from patients who had completed comment cards prior to the inspection was consistent with these views. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment. For example, the practice had

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

a system to identify and prioritise appointments for older patients, who were at risk of deteriorating health, as well as patients with a vulnerability, including those experiencing poor mental health.

There were arrangements to help ensure patients could access urgent or emergency treatment when the practice was closed. Information about the 'out of hours' service was displayed and was also included in the patient information booklet. A telephone message informed patients how to access services if they telephoned the practice when it was closed. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

Information from the national patient survey showed that the practice had been rated generally in line with other practices in the local area in relation to getting appointments and opening times. For example, 71% of respondents said that opening times were convenient, compared to the local average of 68%. The results also showed that 77% of respondents said that they were able to get an appointment the last time they tried, compared to the local average of 81%. The practice was rated less well when respondents were asked about how long they waited to see the GP after their appointment time, with 30% saying they waited less than 15 minutes, compared to the local average of 60%.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. There was a complaints policy and a procedure that was in line with NHS guidance for GPs and there was a designated responsible person who handled all complaints in the practice.

Information was not readily available to help patients understand the complaints system, as the procedure was not displayed in the waiting area, although it was included in the practice information booklet. There were questionnaires available and displayed for patients to complete in order to provide comments and feedback to the practice. We looked at three complaints that had been received in the last year and found that these had been satisfactorily investigated and dealt with in a timely way and in accordance with the practice policy. The complainants had received written apologies.

The practice had produced an annual summary of the complaints it received and held a practice meeting to review the types of complaint, the lessons learned and to identify ways to help avoid similar incidents happening again where this was considered necessary. For example, a review of the administrative procedure in handling patients' documents and information.

Are services well-led?

Inadequate

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

Our findings

The practice did not have a formal written strategy or vision document that set out its future plans in providing care to its patients. However, in speaking with staff, they said that high quality care and good outcomes were promoted for all patients amongst the GPs and staff in the practice and they were aware of their own responsibilities in this respect.

There had been discussion amongst the GP partners and senior administrator to consider future plans for the practice to improve patient outcomes, including increased staffing and how administrative tasks were organised.

Governance arrangements

The practice had identified members of staff to undertake lead roles within the practice. For example, there was a lead for safeguarding and for infection control. However, the practice did not have a designated practice manager to oversee and manage the administrative tasks and some of the staff we spoke with were not clear about their own roles and what was expected of them. We were told that this sometimes created difficulties in that some administrative staff were unsure about their own level of responsibility. Staff said they felt able to approach the GPs with concerns or issues and that these difficulties had been discussed openly.

The overall numbers of staff and range of skills required to meet the needs of patients had not been systematically assessed by the GP partners. There were insufficient clinical nursing sessions to effectively manage the on-going health care needs of patients, particularly those with complex / chronic and long-term conditions. There were insufficient staff to manage the administrative tasks required to support the provision of effective clinical care, for example, the management of the Quality and Outcomes Framework (QOF) data system and the backlog of patient records that required summarising into the computerised system.

The practice did not use the QOF data effectively to monitor outcomes for patients and to measure their own performance in key clinical areas, as the information was not accurately recorded and reported. There was no other system to provide assurance in demonstrating how patients' health care needs were effectively managed, supported or met by the practice. There was no system or process to monitor clinical performance against other practices either locally or nationally.

The practice had undertaken clinical audits and used the information to improve some areas of specific clinical practice. However, the practice had not always undertaken other management audits to monitor the quality and safety of the services provided to patients. For example, a training audit / plan to identify staff training needs, an infection control audit, as well as a review of the business continuity plan to help ensure the contents were kept up-to-date.

The practice had a number of policies and procedures to govern activity and these were available on the computer for staff guidance and reference. We looked at nine of these and saw that the majority had been reviewed in the last year and that staff had access to them.

The practice GPs said they had daily discussions in relation to specific issues about patients' care, although minutes were not kept. General staff meetings were held on a monthly basis which included administration staff and minutes were kept. Discussions included areas of risk, such as patients with palliative care needs, as well as staffing issues.

The practice had arrangements for managing and mitigating risks in relation to the premises, to help keep staff, patients and others safe. The practice used a premises risk log to identify and record how risks were monitored and managed on an on-going basis, such as maintenance checks and tests relating to legionella and electrical equipment.

Leadership, openness and transparency

We spoke with the practice GPs who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. Staff we spoke with told us that the GPs were approachable, and that they felt able to raise any concerns they had with senior staff. They said there was a good sense of team work and that communication worked well.

The practice had a range of human resource policies and procedures. These included a grievance policy, harassment policy and a policy in relation to sickness / absence, which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice also had a whistleblowing policy which was available to all staff on any computer within the practice.

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

Are services well-led?

Inadequate

(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 national patient survey, comments and complaints received, as well as feedback from the NHS friends and family test questionnaires. Results from the questionnaires had identified key areas for improvement, for example, getting through to the practice on the telephone and making appointments. As a result, the practice had planned and implemented actions, including a review of how the available telephone lines were used by all staff, to keep lines free for patients during busier times. Online telephone appointments had also been introduced to help manage patient demand.

The practice did not have a patient participation group (PPG), although they planned to seek members to form a PPG in the coming months. The practice had therefore sought feedback, views and comments from patients in other ways. A survey had been undertaken and the practice planned to review the results and develop an action plan to implement any required changes in the coming year.

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

Management lead through learning and improvement

The practice GPs and nurse accessed on-going learning to improve their clinical skills and competencies, for example, update training for cervical screening and sexual health. Staff said they had dedicated time set aside for learning and development and the GPs attended monthly educational meetings with the area clinical commissioning group (CCG). Formal appraisals were undertaken to monitor and review performance, and to identify and plan the training requirements for all staff.

The practice had shared the outcomes of significant events with staff, to help ensure lessons were learned and changes acted on.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not have established recruitment procedures that operated effectively to ensure that information was available in relation to each person employed for the carrying on of the regulated activities, because Disclosure and Barring Service (DBS) checks, proof of identification and references had not been obtained, as specified in Schedule 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19(3)(a) – Schedule 3

This section is primarily information for the provider

Enforcement actions

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **Systems and processes had not been established and operated effectively to enable the provider to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities and to mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities because;** • management audits had not been routinely undertaken by the provider, including a training audit, infection control audit, and an audit of the contents of the business continuity plan; • the provider did not have a monitoring system to demonstrate and provide assurance that the health care needs of patients were effectively managed, sufficiently supported and met; • the provider did not have a system to assess, maintain and keep under review the staffing levels required to ensure there were sufficient nursing hours to support and manage the health care needs of patients, and to ensure there were sufficient administration staff to undertake and keep all administrative tasks up-to-date; • the provider had not kept the summarising of paper patient records up-to-date, to ensure that the computerised patient records were accurate, complete and contemporaneous. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(1)(2)(a)(b)(c)(f)