Iver Medical Centre

Quality Report

The Iver Medical Centre,
High Street
Iver
Buckinghamshire
SL0 9NU
Tel: 01753 653008
Website: www.iverdoc.co.uk

Date of inspection visit: 07 April 2015
Date of publication: 21/05/2015

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 9

Areas for improvement 9

Outstanding practice 10

Detailed findings from this inspection

Our inspection team 11

Background to Iver Medical Centre 11

Why we carried out this inspection 11

How we carried out this inspection 11

Detailed findings 13

Action we have told the provider to take 24

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Iver Medical Centre on 7 April 2015. Overall the practice is rated as requires improvement.

We found the practice to be good for providing effective and caring services. The practice requires improvement in the provision of safe and responsive services and for being well-led. It also requires improvement for all of the six population groups we assessed.

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.
- Significant events and complaints were not always fully investigated and did not always lead to changes in protocol and practice.
- Communication channels and regular meetings were available to all staff which enabled them to be involved the running of the practice.
- Risks to patients were assessed and well managed including infection control, premises maintenance, equipment checks and emergency procedures.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- There was a system for following up test results but this could have been improved by using the electronic patient record system.
- The practice was involved in several pilots and enhanced services to improve patient care and welfare.
- Staff training was identified, monitored and undertaken to ensure staff could fulfil their roles safely and effectively.
- Patient feedback showed 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 and how to complain was available and easy to understand.
- Patients said they sometimes found it difficult to make an appointment and getting through on the phone could be hard. The practice operated a system of triage, to assess patient need for an appointment. However, we found some patients were referred to walk-in centres even when face-to-face appointments at the practice were still available.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There had a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- There had been changes to the leadership structure. An external consultant service had been used to review management and clinical monitoring of patients' care.

We found one area of outstanding practice:

- Screening of patients considered at risk of dementia had identified more diagnoses of patients with early forms of dementia than any other practice in the Clinical Commissioning Group (CCG).

There were areas of practice where the provider must make improvements.

- Investigate, respond, review and where necessary improve the service based on complaints and significant events.
- Implement a robust programme of clinical audit
- Ensure that patients who need to see a GP at the practice are able to do so and not referred to walk-in centres as a means of accessing care.
- Review and act on patient feedback regarding the appointment system to ensure it meets the needs of the patient population to the best of the practice's ability

Additionally the provider should :

- Complete fire risk assessment and any required actions
- Ensure clinical waste is stored securely
- Review the process for providing flu vaccinations to increase uptake among at risk groups
- Develop a functioning and representative Patient Participation Group (PPG)

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However investigations into complaints and significant events did not always ensure problems were identified and that lessons were learned to ensure improvements were made to the service. Risks to patients associated with premises and the provision of care were assessed and well managed. There were enough staff to keep patients safe. There were systems to ensure medicines were stored correctly and within their date of expiry. An infection control policy was in place and followed. A disaster recovery plan was in place. Safeguarding training was provided and protocols were accessible for staff. There was evidence that staff acted on any concerns related to safeguarding.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Enhanced services were undertaken to prevent unplanned admissions and dementia screening for patients at risk. The practice had a system to ensure staff had received training appropriate to their roles and appraisals were in place to identify further training needs. Staff had an awareness of the Mental Capacity Act 2005 and supporting guidance was in place. Staff worked with multidisciplinary teams in planning and delivering care, such as liaison with district nurses and palliative care teams. There was no comprehensive system of audit but the practice partners were aware of this and were implementing a programme to ensure patient outcomes could be improved where this was necessary.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well in 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 to help patients understand the services was available. We also saw that staff treated patients with kindness and

Summary of findings

respect. Confidentiality was maintained and staff had an awareness of their role in maintaining privacy and preventing private information from being shared. Bereavement support was promoted by the practice.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. It was aware of the needs of its local population, including those who needed additional support in receiving the care and treatment they needed. Many patients said it was difficult to make appointments and many said using the telephone system was a barrier to making appointments. Some patients were being referred to walk-in centres when they tried to make an appointment. Survey feedback regarding the appointment system showed patients often found booking appointments difficult. The practice had taken some action to try and improve appointment booking. There was online booking but patients reported problems with the system to us and very few had taken this service up The practice had good facilities and was well equipped to treat patients and meet their needs. There had been changes to the service to meet patients' needs. Information about how to complain was available and easy to understand.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a clear vision which was available to patients. Staff were clear about the practice vision and their responsibilities in relation to this. The practice had considered and was in process of planning for its future in response to changes in their partnership and to the practice manager. External professionals had been brought in to help the practice plan its strategy for the future and monitor clinical care. 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 governance meetings. There were systems in place to monitor and improve quality and identify risk. However, the practice did not always investigate and complete actions related to significant events and complaints. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was a virtual reference group and was not yet fully functional. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated requires improvement for the domains of safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. End of life care was well managed and included external professionals in its planning and implementation. It was responsive to the needs of older people, and offered home visits, regular reviews of care for patients in a local care home and rapid access appointments for those with enhanced needs. The premises were easily accessible for patients with limited mobility and they were being altered to enable services to be provided on the first floor. Plans for patients at risk of unplanned admissions to hospital were written to reduce the risk of this occurrence. The practice had the highest early diagnosis of dementia within the locality.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long term conditions. The provider was rated requires improvement for the domains of safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Chronic disease management was well managed within the practice, and this was reflected in national data and patient records. Plans for patients at risk of unplanned admissions to hospital were written to reduce the risk of this occurrence. Longer appointments and home visits were available when needed. The practice had ensured that the coding for specific conditions was reviewed and had a high accuracy rate. This enabled the practice to plan and implement care appropriately for patients who had long term conditions. There were leads for managing specific roles such as diabetes and respiratory diseases. This enabled staff to provide expertise in caring for these conditions. Nurses received training to provide reviews of patients in this population group. There was concern that patients with long term conditions may be referred to local walk-in centres rather than seeing their own GP.

Summary of findings

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families and young people. The provider was rated requires improvement for the domains of safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, and systems to ensure staff were aware when seeing children who were at risk of harm or abuse. Immunisation rates were close to average for most standard childhood immunisations. The premises were easily accessible for patients attending with prams and buggies. Sexual health advice and services were available to patients. Midwives visited the practice twice per week to hold clinics. Patients requiring further maternity services outside of these clinics were referred to Wexham Park Hospital.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider was rated requires improvement for the domains of safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Some patients found it difficult to book appointments, in particular those patients who worked full time. However, 93% of patients also reported that the last appointment they attended was convenient, above the average for the locality. Extended hours appointments were available. The practice provided a full range of health promotion and screening that reflected the needs of this age group. New patient health checks were offered. Phone consultations were available which provided flexibility in accessing advice from nurses or GPs.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated requires improvement for the domains of safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice had carried out responsive checks for patients with a learning disability and offered these patients longer appointment slots. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told 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

Summary of findings

safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice worked with external services in pilots to provide services suited to vulnerable patients' needs. This included assessing patients who had been discharged from hospital in terms of their nutrition and hydration and providing home visits in partnership with a local ambulance service. Staff confirmed that any patients who did not have an address to provide to the practice, would still be seen by an appropriate clinician.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia**)**. The provider was rated requires improvement for the domains of safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Patients experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and early screening for the disease. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Counselling was available to patients on-site.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey and a survey of 60 patients undertaken by the practice. We also considered evidence from the feedback we received on the day from 19 patients and 20 completed CQC comment cards. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed 84% of practice respondents said the GP was good at listening to them and 78% said the GP gave them enough time. Eighty six per cent said the last nurse they saw or spoke to was good at listening to them and 88% said the last nurse they saw or spoke to was good at giving them enough time.

Patients said they felt the practice offered a caring and helpful service. Some comments were less positive but these related to the appointments system. Patients noted being treated with respect and dignity on the comment cards. Eighty four per cent of patients said the last GP they saw treated them with care and concern and 87% said the last nurse they saw treated them with care and concern on the national survey.

The GP national patient survey showed patients felt involved in consultations with nurses, as 87% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care.

Eighty one per cent of patients said the last GP they saw or spoke to was good at involving them in decisions about their care. Feedback from patients we spoke with and from comment cards showed no concerns regarding involvement in care and treatment.

We received information from a member of the public who was concerned that a patient had required a post-natal appointment but was referred to a walk-in centre. Some of the patients we spoke with on the day of inspection told us they had been asked to attend walk-in centres by the practice in the past when they were unable to access an appointment that day. We spoke to the practice about this issue and they confirmed that a duty doctor triages appointments. They also explained that the practice provides an appointment to the patient from availability of on the day of contact or offers a routine appointment at a later date.

Patients reported difficulty in booking appointments at the practice. In the 2014 GP survey only 80% of patients said they were able to get an appointment to see or speak to someone the last time they tried. Only 63% of respondents found it easy to get through to this surgery by phone in the 2014 GP survey compared to 71% average in the locality. On the practice survey 50% of patients said it was not very easy or not at all easy to get through by phone.

Areas for improvement

Action the service MUST take to improve

- Investigate, respond, review and where necessary improve the service based on complaints and significant events.
- Implement a robust programme of clinical audit
- Ensure that patients who need to see a GP at the practice are able to do so and not referred to walk-in centres as a means of accessing care.
- Review and act on patient feedback regarding the appointment system to ensure it meets the needs of the patient population to the best of the practice's ability

Action the service SHOULD take to improve

- Ensure clinical waste is stored securely.
- Complete fire risk assessment and any required actions.
- Develop a functioning and representative Patient Participation Group (PPG)
- Review the process for providing flu vaccinations to increase uptake among at risk groups

Summary of findings

Outstanding practice

- Screening of patients considered at risk of dementia had identified more diagnoses of patients with early forms of dementia than any other practice in the Clinical Commissioning Group (CCG).

Iver Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector**.** The team included two GP specialist advisers, a practice nurse and a second CQC inspector.

Background to Iver Medical Centre

Iver Medical Centre is located in the village of Iver. The practice premises were purpose built within the last 20 years. Patients are registered from the local area. The practice population has a higher proportion of patients aged 40-65 compared to the national average. There is minimal deprivation according to national data. The prevalence of patients with a long term health problem is 48% compared to the national average of 54%. Local traveller communities and those living in canal boats are registered at the practice.

9,600 patients are registered with the practice. The practice population had increased by approximately 1000 patients in the last year due to the closure of a local practice

Care and treatment is delivered by five GP partners, one practice nurse, one nurse practitioner, one health care assistant a practice manager, deputy manager and administration staff.

The practice is a member Chiltern CCG.

Services are provided from

Iver Medical Centre, High Street, Iver, Buckinghamshire, SL0 9NU

This is a training practice. The practice had a General Medical Services (GMS) contract. GMS contracts are nationally agreed between the General Medical Council and NHS England.

We visited the Iver Medical Centre but did not visit Iver Heath Health Centre as part of this inspection. The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider and NHS 111.

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. 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, Regulated Activities Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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.

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning

Detailed findings

group (CCG), local Healthwatch, NHS England and Public Health England. We visited Iver Medical Centre on 7 April 2015. During the inspection we spoke with GPs, nurses, the practice manager, deputy manager and reception staff. We obtained patient feedback from speaking with patients, comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant records relating to training, recruitment, maintenance and cleaning of the premises.

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 were communicated and investigated. The practice had a protocol for disseminating medicine and safety alerts. These were identified weekly by the deputy manager and communicated via meetings and emails.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw evidence that there were numerous meetings where incidents could be discussed regularly. We reviewed safety records, incident reports and minutes of meetings where these were discussed in team meetings. However, when the practice identified actions from incident reviews to improve safety, we found little evidence in minutes that these were discussed at a later date to check that the actions were followed through.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and investigating significant events, incidents and accidents. There were records of significant events that had occurred in the last year and we were able to review these. The practice was proactive at recording complaints and incidents on a log for staff to review and discuss at team meetings. The list of complaints and significant events recorded was extensive. Some events had led to systematic change, such as longer appointments for patients who suffer from mental illness as a result of one recorded incident. Staff told us significant events were investigated and discussed at relevant staff meetings. However, we saw complaints related to alleged misdiagnoses were received by the practice but were not investigated fully. The alleged misdiagnoses had not been investigated because the practice concluded that as a relative had made the complaint and there was no consent to investigate the concerns. The practice could have investigated the concerns raised to identify if there was any fault on the part of the practice, any action required for the patient involved or any learning outcomes. The lack of consent from the patients involved did not mean the practice should not have investigated the concern, but that they could not share the outcome with anyone externally without the patients' permission.

Where the practice did investigate concerns it identified individual actions to improve safety and services. There was little evidence that there was follow up or trend analysis of these concerns over time. Three incidents on the significant event log related to emergency medicines not being in date or appropriate, but significant event analysis had not specifically identified any concern in the checking of emergency medicines. The lead nurse had personally identified the concern and changed the process for checking emergency medicines and equipment and we found this process had ensured the equipment and drugs were in date and working. The lead nurses also changed the process for monitoring patients' blood pressure over a period of time to gather an accurate reading, in response to a significant event. This improved the accuracy of the blood pressure checks for patients at risk of high blood pressure. However, this had been the result of one staff member identifying the concern rather than the significant event review process identifying the trend and discussing this at practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. GPs had undertaken level three child safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to all staff. GPs had meetings with health visitors every six weeks to discuss at children considered at risk of abuse.

The practice had appointed a dedicated GP as a lead in safeguarding vulnerable adults and children. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding

concern. There had been an occurrence of a receptionist raising a concern about a potentially vulnerable adult with the GP safeguarding lead. The lead looked into the concern to ensure the welfare and safety of the patient.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plans. We saw examples of how the system flagged patients who may be at risk of abuse.

There was a chaperone policy which was visible in consulting rooms and in the entrance area of the practice. Nurses and receptionists undertook chaperone duties and the manager informed us they had all been trained as chaperones.

Medicines management

We checked medicines kept in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a schedule for checking that medicines were kept at the required temperatures. Staff knew what action to take in in the event that a fridge should stop working, such as a power cut. We saw records of temperature checks were regularly undertaken and that the temperatures were within the required range to ensure medicines were stored appropriately. The practice took action when the checks of fridge temperatures showed that they were not sustaining the required temperatures. For example, two fridges had been taken out of use as a result of high temperature measurements. Staff who took receipt of and who administered vaccines told us they received training to do so.

Processes were in place to check medicines stored in treatment rooms 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 nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance Health care assistants (HCA) were in the process of being trained to administer certain injections, such as vitamin B12, at the time of the inspection. Nurses administered vaccines under patient group directives which enable non-prescribers to provide certain medicines under the authority of an approved prescriber.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy, specifically treatment and consultation rooms. The practice had a schedule of cleaning which was followed. The practice staff undertook checks on the cleanliness of the premises. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. They were aware of their responsibilities in monitoring and managing infection control. They undertook regular audits and we saw actions from the audits were planned and most were implemented. There was a cleaning action log book which the infection control lead had responsibility for. All staff received training about infection control specific to their role Hepatitis B immunisations were provided to staff and a log of staff immunisation status was kept up to date.

The infection control policy contained supporting documentation and was available for staff to refer to. This included a sharps injury, hand hygiene and blood and body fluid spillage protocols and these were available to staff. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Hand washing sinks with liquid soap, hand gel and hand towel dispensers were available in treatment rooms. Sharps boxes were available in treatment and consultation rooms and were only filled up to the maximum mark. Filled boxes were removed. Sharps boxes were stored in a cupboard but this was not locked to keep the boxes secure prior to collection. External clinical waste bins were locked but were not chained or locked up to prevent them being removed.

The practice had undertaken a risk assessment on legionella. (a bacterium that can grow in contaminated water and can be potentially fatal). Any action recommended by the assessment had been completed. For example, a shower was taken out of use.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested

and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment. For example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer were all calibrated annually. When equipment failed calibration tests, it was replaced or taken out of service.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting staff. Since October 2014 the practice had ensured that staff recruited had a reference from any previous roles where they worked in health or social care services. Some of the files prior to this date did not have references.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was minimal use of external covering staff, such as locum GPs, which showed that cover arrangements worked well in the practice. There had been staff unexpectedly leaving or on long term leave in the last year and the practice had been able to ensure continuity in the running of the service.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had health and safety literature available to its staff. A comprehensive risk assessment related to health and safety had been undertaken and this identified the need to undertake a fire risk assessment. We saw evidence that this had been planned.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all 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 of their location. They included medicines for the treatment of a variety of medical emergencies. Processes were in place 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.

We saw a business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw evidence that new guidelines were disseminated and that the practice's performance was reviewed where necessary. We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs led in clinical areas and had, or were in the process of, undertaking training relevant to these roles such as diabetes and respiratory diseases. Nurses received training to enable them to lead in specific long term conditions. This enabled the practice to effectively manage specific long term conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of specific medical conditions. We saw clinical meeting minutes which confirmed this happened.

We completed a review of case notes for patients with various long term conditions which showed all were receiving appropriate treatment and regular review. The practice had employed an external consultant to assist them in identifying ways of improving the diagnosis of certain conditions. This involved improving the coding of patients on the computerised patient record system which enabled the practice to screen for conditions which patients may have been at risk of. This led to the highest diagnosis rate of dementia among any of the practices in the clinical commissioning group (CCG).

Care plans were created as part of an enhanced service (a funded service beyond the contractual obligations of the practice) for 3% of the patient population which is above the 2% target. GPs told us that when the practice was notified of admissions, the care plans were reviewed by a dedicated GP and patients were either contacted or visited to ensure their care panning was appropriate.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice's total outpatient expenditure in relation to its registered population was 78% compared to the national average of 92%. Elective admissions to hospital matched the national average of 12%. The care plans were shared with other health services such as ambulance crews and district nurses so care plans could be seen in emergencies and out of normal GP hours. The practice screened nearly 700 patients for Atrial Fibrillation in the last year and nine patients were identified who were then placed on treatment to reduce their risk of strokes.

Clinical consultants could provide expertise to GPs in the care of specific conditions through a consultant led clinic. The practice participated in a local pilot to contact any patients aged over 75 after discharge for a review including nutrition, hydration, wound care, medication review and there was liaison with other services.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us several clinical audits which had been undertaken in recent years. Audits were undertaken in response to medicines management information, trainee GP's learning needs, safety alerts or as a result of information from the quality and outcomes framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice had identified that there was no overall programme of audit aimed at benefitting the practice. Audits were undertaken by individual GPs or trainees and were rarely completed to ensure learning outcomes led to changes in practice. The lead partner explained that the practice was in the process of identifying uncompleted audits and developing an audit programme.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed well on QOF across the majority of clinical outcomes for patients achieving 97% overall in 2014. Exception reporting was slightly higher in some areas of patient care. Exceptions may be made when patients are not able to be seen or not able to receive treatment in line with national standards. The practice was a low prescriber and was 17% under its prescribing budget in the last year.

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.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support and safeguarding. There was a training log which identified what training was required by staff and when this would need to be updated. We noted a good skill mix among the GPs and nurses. All the GPs attended local meetings to discuss clinical topics with other GPs and share learning. All GPs were up to date with their yearly continuing professional development requirements and all either have 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice had induction plans for different staff roles which included various aspects of training specific to the practice's policies and protocols. All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was responsive when staff identified training needs they were supported and funded for relevant courses. Nurses attended courses for the care of patients with specific conditions.

There were systems in place to disseminate relevant learning through team meetings. These were regularly attended by all staff. We saw minutes of the various team meetings.

Working with colleagues and other services

The practice worked with other service providers to provide patients' care including those with complex care needs. It 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. Test results returned from laboratories which were non-urgent, but required GPs to review them, were passed onto the relevant GP on a hard paper copy with a slip detailing the action required. The use of an electronic system for reviewing the test results was available and this system would reduce the likelihood of results being mislaid.

The practice worked with the district nursing team, health visitors and midwifes. GPs told us there was a multi-disciplinary team meeting every month. This included the district nurses, health visitors and palliative care nurses. The minutes of the meetings showed us that care of patients that required the input from various staff was discussed to ensure coordinated care was given. There was evidence of working with other healthcare professionals and voluntary bodies. A pilot was run in partnership between the local ambulance services and the practice to help provide home visits to patients who benefitted from receiving them during the morning rather than later in the day.

Information sharing

The practice used electronic systems to communicate with other providers and internally. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals and the practice used the Choose and Book system (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Good

Are services effective?

(for example, treatment is effective)

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Patients who had care plans due to the risk of admission to hospital did not have their care plans stored on the main patient record system.

Consent to care and treatment

We found that GPs and nurses were aware of the Mental Capacity Act 2005. All the staff we spoke with understood the key parts of the legislation. There was guidance made available to staff following an occurrence where the Act needed to be followed. Staff gave examples of when they would need to refer the principle of the Act. There was an assessment form available in order for staff to follow the principles of the act in assessing patients' capacity and we saw this had been used appropriately. We saw evidence of staff gaining consent from patients for specific procedures.

Staff were aware of the Gillick Competencies (this refers to the rights of children to make decisions about their treatment between the ages of 13-16). Staff told us they were aware of their responsibility to gain consent from patients and we saw evidence in patient records that consent was discussed.

Health promotion and prevention

GPs told us of a range of health promotion services they were able to access for their patients. For example, counselling was available in the practice. The practice participated in a countywide project to assist diabetics manage their conditions safely. The practice worked with the local drug and alcohol support service. The website contained a link to the NHS live well advice service and also held health information for its patients including planning for children, pre-natal care advice, men's and women's health, child health and sexual health. A range of health promotion information was available in both the main waiting area and in clinical rooms. Health checks were offered to new patients.

The practice kept a register of all patients with a learning disability but they were not offered an annual health check. The practice had also identified the smoking status of 86% of patients over the age of 16 (above the national average) and actively offered nurse-led smoking cessation clinics to 76% of these patients. The practice records indicated that 14 patients had quit smoking as a result of the smoking cessation advice and support.

The practice's performance for cervical smear uptake was 81% in recent years, which matched the national average and target of 80%. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations close to the average for the CCG with an average across all child age groups of 90%. Flu vaccinations were offered and the uptake among those over 65 was low in 2013/14 at 62% and 36% for patients under 65. In 2014/15 the practice provided Saturday morning flu clinics were introduced in 2014 to try and increase the uptake of flu vaccinations. However, the practice achieved 66% uptake over 65 years old and 34% for those eligible under 65. Nineteen per cent of patients had refused the vaccine when offered.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 60 patients undertaken by the practice. We also considered evidence from the feedback we received on the day from 19 patients and 20 completed CQC comment cards. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed 84% of practice respondents said the GP was good at listening to them and 78% said the GP gave them enough time. Eighty six per cent said the last nurse they saw or spoke to was good at listening to them and 88% said the last nurse they saw or spoke to was good at giving them enough time.

Patients said they felt the practice offered a caring and helpful service. Some comments were less positive but these related to the appointments system. Patients who completed CQC comment cards referred to being treated with respect and dignity. Eighty four per cent of patients said the last GP they saw treated them with care and concern and 87% said the last nurse they saw treated them with care and concern on the national survey.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The reception desk was located away from the waiting area to reduce the risk of patients overhearing conversations at the reception desk. Calls were taken in a back office to ensure patients could not overhear potentially private phone conversations.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatment so that confidential information was kept private.

Care planning and involvement in decisions about care and treatment

The GP national patient survey showed patients felt involved in consultations with nurses, as 87% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care. Eighty one per cent of patients said the last GP they saw or spoke to was good at involving them in decisions about their care. Feedback from patients we spoke with and from comment cards showed no concerns regarding involvement in care and treatment. We found that care planning as part of an enhanced service included patients fully in the creation of the plans. There was a protocol for including patients in decisions relating to do not attempt resuscitation forms where this was possible and also relatives where patients could not be included due to a lack of capacity.

Staff told us that translators were available to be booked for patients who did not have English as a first language to enable them to discuss and be involved in their care and treatment.

Patient/carer support to cope emotionally with care and treatment

A bereavement service was promoted online to support patients through loss of people close to them. The practice survey found that 94% of patients felt they were treated with care and concern by their GP and 87% felt treated with care and concern by nurses. Notices in the patient waiting room informed patients of how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Support services for patients with mental health conditions were promoted by the practice. We saw evidence that the practice promoted bereavement support to the families of patients who were receiving end of life care.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The diversity of the practice population was understood by staff within the practice and systems were in place to address identified needs in the way services were delivered. This included recognition of local traveller communities and those at non-fixed addresses such as a local canal boat community. The practice manager told us that if a homeless person needed to see a GP at the practice, there would be a temporary registration made for them. The practice had a higher proportion of patients between 40 and 65 than the national average. It had a smaller young population than the national average.

Height adjustable benches, which made it easier for patients who had limited mobility, were available in consultation rooms and the practice had ordered more of these to increase accessibility of services within different treatment rooms within the practice. Staff told us some patients found the choose and book system of making appointments at external services a little difficult and as a result, the practice secretary supported some patients in using the choose and book system.

Patients who required travel immunisations or health advice could receive this at the practice. Two to three hours allocated time for visits to a local nursing home was planned into a named GP's weekly schedule, facilitating continuity of care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services including a phone translation service. This made it easier for patients with urgent concerns who did not speak English to access care and treatment at the practice. Staff told us that there were very few non-English speaking patients. There was recognition that some patients on long term medicines were not able to follow their prescribed doses easily. The practice responded by prescribing the medicines in blister packs, which made it easier to follow the required doses of medicines. Travellers were encouraged to attend for vaccinations and measures were in place to work with them to manage their long term conditions more effectively.

The premises and services had been adapted to meet the needs of patient with disabilities or limited mobility. Level access at the front of the building made it suitable for wheelchairs and mobility scooters. An automatic door had also been fitted. The practice had considered putting a lift in place but this was not possible due to the restriction of the building. Staff told us that all patients who needed an appointment on the ground floor were flagged on the patient record system so they could be offered one. The premises had wide corridors and doorways were wide enough for large wheelchairs.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8:30am to 12:00pm and afternoon surgeries ran from 1:30pm to 5:30pm. Late appointments were available on Monday and Tuesday evenings and early appointments available on Tuesday and Wednesday mornings as part of the extended hours service. Patients could book appointments in advance or for the same day via online booking, in person or on the phone. There was a triage system for same day appointments booked via the phone. There was not a high uptake of online booking with patients, as this was a relatively new service and patients reported problems in using the online booking tool. Some patients told us the unreliability of online booking put them off using the service. The practice was not aware of this problem with the system when we reported it to staff. Twelve same day appointments were available and could be provided by the duty doctor who called patients back requiring a same day appointment. If the duty doctor deemed the patient needed an appointment they could use these slots. There was also an evening phone consultation service for patients who called for an appointment after the morning triage was finished. This meant if a patient called after the duty doctor had finished calling patients back to determine if they needed a same day appointment, the practice could still offer a phone consultation in the evening.

Some of the patients we spoke with told us they had been asked to attend walk-in centres by the practice when they had asked for a same day appointment. One told us they

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

had decided to attend a walk-in centre because they could not get an appointment. We received information from a member of the public who was concerned that a patient they knew had required a post-natal appointment but was referred to a walk-in centre. We asked the lead partner why some patients may be diverted to a walk-in centre and they told us this could be if the demand on the practice was too high. The practice did not have any data on how many of its patients were attending walk-in centres at the time of the inspection. The lead partner told us the practice had recently requested this information from the CCG. We looked at how many of the same day appointment slots were used over the week beginning 30 March. Over the four working days 48 appointments were made available for booking the same day but 15 slots were not used. This was despite 82 patients requesting an appointment and being called back to assess whether they needed one over the course of the week.

Patients reported difficulty in booking appointments at the practice. In the 2014 GP survey only 80% of patients said they were able to get an appointment to see or speak to someone the last time they tried. Only 63% of respondents found it easy to get through to this surgery by phone in the 2014 GP survey compared to 71% average in the locality. On the practice survey 50% of patients said it was not very easy or not at all easy to get through by phone. In response to this the practice had provided extra phone lines including mobile phones to meet the demand on their phone lines. GPs we spoke with recognised the concerns of patients in getting appointments. There was positive feedback regarding the convenience of appointments with 93% of patients stating the last appointment they got was convenient in the 2014 GP survey, above the local average.

Staff told us they planned for potential demands on the practice. For example on the day of the inspection, two GPs had been allocated to the triage system to deal with the extra demand of patients anticipated after the bank holiday weekend.

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients who required them, by a named GP and to those patients who needed one.

Listening and learning from concerns and complaints

The practice had a 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. We looked at several complaints and found they were responded to. However the process for investigating them was not followed in three of the complaints regarding misdiagnoses we reviewed. We saw that information was available to help patients understand the complaints in the form of information in the practice and on the website.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The website provided the practice mission statement to patients which included the key themes of providing high quality safe and effective primary care services, that were patient centred and to help patients to be aware of their health needs, promoting choice and using NHS resources responsibly. There was planning for the future demand of the practice and plans to increase capacity in terms of treatment and consultation rooms. The practice had incorporated a patient list of over 1,000 patients from another practice which had closed within the last year. GPs told us there had been an increase in appointments to accommodate this increase in numbers. Since this sudden change in patient population the practice had been able to cap its patient list. The previous lead partner had left in the last year and this had meant that a change in governance structure was required. The practice had also undergone a change in practice manager. During these changes, the practice had brought in consultants to review clinical and managerial processes. This had led to changes in governance and the way clinical care was monitored.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at policies and found most were reviewed regularly and up to date. Policies and protocols were introduced to support staff in their roles. For example, a Mental Capacity Act 2005 policy was sourced from an external provider to support staff when it was identified as a potential benefit.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. The leads in these areas had their roles clearly defined and were proactive in delivering changes. For example, the lead nurse changed the process of checking emergency medicines in response to a number of significant incidents regarding medical emergencies where medicines were not ready for use. Staff were clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at staff meetings. Coding on the electronic records system of patients with specific conditions or at risk of developing certain conditions had been improved to help identify patients' needs and to ensure the work undertaken by the practice was recognised.

The practice had some clinical audits which it repeated and completed to monitor quality and improve outcomes for patients. However, the practice had recognised there was no overall programme of audit and was trying to implement one.

The practice had arrangements for identifying, recording and managing risks. A generic assessment had been carried out on the premises and identified where further assessments were required. For example, there a fire risk assessment and asbestos register were planned at the practice.

Feedback regarding nurse consultations led the practice to undertake a focussed survey on patients' opinions of nurse interaction. This focussed survey found no concerns from patients and that consultations with nurses were highly regarded.

Leadership, openness and transparency

We saw minutes from weekly partnership meetings and monthly clinical and regular multi-disciplinary meetings. Staff were able to attend a meeting at least once a month. Nurses met with the partners monthly. The practice manager told us that they were undertaking a review of the structure of these meetings to ensure that action points were captured and followed up at subsequent meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or to their line manager or a GP if required. Staff we spoke with knew who to report concerns to about specific issues such as safeguarding and also had line managers from whom they could access support if needed. The practice had an away day within the last year and all the staff attended.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Requires improvement

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

The practice had gathered feedback from patients through patient surveys and used external feedback from the national GP survey. We looked at the results of the annual patient survey and saw there was some negative feedback about the telephone system and accessing appointments. The practice had responded to this feedback by adding telephone lines and had implemented online booking. However, this implementation had not been followed up with appropriate checking that the system worked properly. Patients told us that the system did not work well and no patient feedback had been sought by the practice during the trial period which was reported on by a trainee GP. The practice had a virtual patient participation group (PPG) which was communicated with via e-mail. GPs told us the group was still in need of development and was not yet fully functional and was hoping to develop a group that would physically meet to as a PPG.

The practice had gathered feedback from staff through 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 in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at several staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they could attend external training events. The practice was a training practice and we spoke with doctors in training. They were complimentary about the support they received at the practice. Trainees were required to undertake audits as part of their development.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. Actions were noted for individual staff to complete. However, we noticed that these actions were not followed up at the subsequent meetings to ensure changes had been made. The practice had identified a high number of significant events, but had not always identified trends, such as the emergency medicines concerns from three separate incidents. The lead nurse had identified the trend independently and taken responsibility to change the system for checking these medicines. Three potential misdiagnoses which had been reported through complaints, had not been investigated to identify any learning or changes which may have been required by the practice.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. How the regulation was not being met: The provider did not operate effective systems and processes to assess, monitor and improve the quality and safety of the services provided. The provider did not always act on feedback from relevant persons on the services provided to evaluate and improve services. Regulation 17(1)(2)(a)(e)