Sternhall Lane Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sternhall Lane Surgery on 9 August 2016. The overall rating for the practice was requires improvement. The full comprehensive report from the inspection undertaken on 9 August 2016 can be found by selecting the 'all reports' link for Sternhall Lane Surgery on our website at www.cqc.org.uk.

As a result of our findings from this inspection CQC issued a requirement notice for the identified breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically we found concerns related to the management of emergencies, sufficient numbers of permanent clinical and administrative staff, training that had not been completed and the lack of action taken to mitigate risks identified.

This inspection was undertaken within 12 months from the last inspection as the practice was rated as requires improvement for two of the key questions; are services safe? and are services well led? This was an announced comprehensive inspection completed on 11 July 2017. While (most of) the issues leading to the breaches in 2016 had been resolved, overall the practice remains rated as requires improvement.

Our key findings at this inspection were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. However there was limited evidence of learning from significant events and not all staff were aware of how to report a significant event or involved in discussions.
- Although the practice had systems in place to minimise risks to patients stemming from equipment we found that prescriptions were not being managed safely. There had been no infection control audit undertaken within the last 12 months, fire drills were not recorded and we found an expired paediatric mask with the practice's oxygen supply.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However not all staff had received the level of

Summary of findings

safeguarding training as specified in their safeguarding policy, GPs working at the practice had not received an internal appraisal and clinical updates were not being discussed regularly in clinical meetings.

- Performance against national clinical targets was comparable to local and national performance. However the practice had not undertaken any analysis of higher rates of exception reporting to ensure that their decision to exclude patients from assessments was clinically justified. We also found that the bowel and breast screening rates were below local and national averages and that the practice was below the national target for the delivery of one child immunisation. Only four of the practice's 23 patients with learning disabilities had received an annual healthcheck in the last 12 months.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns. However we found that complaints responses were not always recorded and responses did not contain information about how patients could escalate complaints if they were dissatisfied with the practice's response.
- Some patients we spoke with said they found it difficult to make an appointment with a named GP which impacted on continuity of care. The practice had recently recruited new salaried staff members in an effort to reduce the practice's reliance on locums. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

The areas where the provider should make improvement are:

- Consider ways to increase the number of patients with learning disabilities who receive an annual health review.
- Continue to engage with the premises owner regarding premises improvements.
- Work to increase the uptake of breast and bowel screening and improve child immunisations in areas that are below the national target.
- Review and risk assess frequency of infection control training for non clinical staff
- Improve systems to monitor the expiry date of emergency medical equipment.
- Discuss clinical updates in practice meetings.
- Consider a system of internal appraisal for salaried GP staff.

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?

Inadequate

The practice is rated as inadequate for providing safe services.

- The practice had systems in place for recording and reporting significant events. There was evidence that significant events were reported and discussed in practice meetings. However from discussions with staff it was evident that learning from significant events was not being cascaded effectively and some staff were unsure of the process for reporting a significant event and not involved in discussions.
- An infection control audit had not been completed since February 2016 and we found that the systems and processes related to the management of medicines did not ensure that patients were kept safe as prescription usage was not being monitored and there was no effective system in place to review uncollected prescriptions with sufficient regularity. The practice had systems, processes and practices to minimise other risks to patient safety including those associated with equipment and fire.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. However staff had not received the level of training outlined in the practice policy and there was an outdated child safeguarding policy stored alongside the current version.
- We found an expired paediatric oxygen mask stored with the practice's emergency equipment. Aside from this issue we found that systems for responding to emergencies and major incidents were sufficient.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average. However the practice had higher levels of exception reporting in respect of some areas of long terms disease management. The practice provided an explanation of why exception reporting was higher and provided evidence of

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analysis to support these explanations after the inspection. However it was evident that reviews of high exception reporting rates were not being undertaken annually to ensure that exclusions were clinically justified.

- There were systems in place to ensure staff had access to current evidence based guidance and there was evidence of audits being undertaken to ensure compliance with guidelines. However we did not see evidence that guidance would be discussed in clinical meetings.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for most staff although there was no system in place to internally appraise salaried GPs working in the practice.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example the practice supported a number of services in the CCG and dedicated clinical sessions and staff to focus on providing care and support to these services. For example the practice supported three nursing residential homes catering to approximately 400 people. The practice also held a session at a local detox clinic and provided three sessions per week at a local refugee centre.

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- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it difficult to make an appointment with a named GP and that this impacted on continuity of care. Urgent appointments were available the same day. Some of the patients we spoke with said it was difficult to get same day appointments though all patients with children said that children would be seen on the day if required.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from three of the four examples reviewed showed the practice responded quickly to issues raised. However in one instance the complainant had provided additional responses and there was no evidence that the practice had provided a reply.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice aimed to deliver high quality care and had recruited additional staff since our previous inspection to improve the consistency of service and continuity of care. However we found that systems and processes to ensure that patients were kept safe did not always operate effectively and impeded on the practice's ability to deliver the vision.
- There was a clear leadership structure and staff felt supported by management.
- There were some areas where the policies used to govern activity were not effective particularly in respect of medicines management and significant events.
- Deficiencies in governance impeded the delivery of the strategy and good quality care. This included arrangements to identify and act on risk. However there was evidence of quality improvement work being undertaken by the practice.
- Staff had received inductions, annual performance reviews and attended training opportunities. However there was no system in place for internal GP appraisals and information from staff meetings was not always shared effectively.
- The provider was aware of the requirements of the duty of candour and had systems in place to comply with these requirements.
- Leadership within the practice encouraged a culture of openness and honesty. The practice had systems for being

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aware of notifiable safety incidents and sharing the information with staff. However it was not always clear what action had been taken in response to safety alerts and not all staff were aware of the practice's significant event process.

- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- Staff training was a priority.
- There was a focus on continuous improvement at the corporate level of the organisation.

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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 inadequate for providing safe and requires improvement for the provision of effective and well led services leading to the practice being rated as requires improvement overall. The issues identified impact on the care provided to this population group.

- The practice provided ten GP session to three nursing homes. The same GPs provided these sessions each week to ensure continuity of care. NHS England contacted CQC to inform them they are satisfied with the quality of care and treatment the practice provides to these services.
- One of the practice's administrative staff was a trained phlebotomist who provided weekly clinics for patients over 60.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care through participating in a local admission avoidance scheme. It involved older patients in planning and making decisions about their care, including their end of life care. These patients were flagged on the practice's computer system to ensure that reception knew these patients were a priority.
- The practice updated the care plans for older patients discharged from hospital to ensure these were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. For example the practice would refer patients over 50 who required additional support to a local organisation that aimed to maintain the independence of older people by helping with their health and social needs.

Summary of findings

People with long term conditions

Requires improvement 

The practice is rated as inadequate for providing safe and requires improvement for the provision of effective and well led services leading to the practice being rated as requires improvement overall. The issues identified impact on the care provided to this population group.

- The practice nurse led in long-term disease management and ran weekly patients for patients with diabetes and chronic obstructive pulmonary disease. Patients at risk of hospital admission were identified as a priority.
- Practice performance for 2015/16 was slightly lower in respect of well control blood sugar levels when compared with local and national averages in the same period. Unverified data provided by the practice for 2016/17 showed that performance in this year was comparable. All other diabetic indicators for both periods were in line with local and national averages.
- The practice reviewed discharge summaries and other information from secondary care for patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- There was a system to recall patients for a structured annual review to check their health and medicines needs were being met. We were told that annual reviews were predominantly undertaken by the practice nurse and the lead GP who was not currently working at the practice. Other GPs spoken to said that they would undertake these reviews opportunistically. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice nurse told us that she would be able to ask for advice from expert clinicians in secondary care where required and the practice held virtual clinics where the care of complex patients would be reviewed with the support of consultants from secondary care.
- The practice hosted a dietician who provided advice and support to patients with long term conditions where appropriate. Patients could also be referred to a local gym as part of a local health living initiative.

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Families, children and young people

Requires improvement

The practice is rated as inadequate for providing safe and requires improvement for the provision of effective and well led services leading to the practice being rated as requires improvement overall. The issues identified impact on the care provided to this population group.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- At the time of our inspection the practice safeguarding lead was not working at the practice. In the interim staff were aware that any safeguarding concerns had to be reported to the practice manager who would inform a clinician working that day who would take appropriate action. The practice had policies for child safeguarding though we found old policies containing out of date information which had not been archived.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, 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.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics. Child immunisations and mother and baby checks were all dealt with in a single appointment. Parents were sent a birthday card and fridge magnet with details of child immunisations by the practice.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications. The practice had a policy of seeing all children under 5 where parents have requested an emergency appointment. When no appointments are available the duty GP will call the parents back and offer an appointment if appropriate. Patients we spoke to on the day confirmed that there was good access to emergency appointments for children.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as inadequate for providing safe and requires improvement for the provision of effective and well led services leading to the practice being rated as requires improvement overall. The issues identified impact on the care provided to this population group.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours. The practice offered its extended access between 7 am and 8 am on Thursdays and Fridays in response to feedback from patients.
- As a member of Hurley Clinic Partnership practice patients could access consultations online by uploading their symptoms to a web template which would be reviewed and acted upon within 24 hours. The software ensured that patients who required urgent attention were directed to the emergency services.
- The practice would open on some Saturdays to offer cervical screening to working patients.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as inadequate for providing safe and requires improvement for the provision of effective and well led services leading to the practice being rated as requires improvement overall. The issues identified impact on the care provided to this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and any patient deemed at risk. Patients who had no proof of residence or identification would be able to register or see a clinician including homeless patients and those removed from other GP patient lists because of violence.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability. However we saw that in 2016/17 only four of the practice's 23 patients with learning disabilities had received an annual review.

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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. In the absence of the practice's safeguarding lead staff all told us they would report concerns to the practice manager and the practice manager confirmed that this was the procedure. The practice had comprehensive child safeguarding and at risk adults policies. However we found an old child safeguarding policy which had not been archived with a former employee noted as the practice lead.
- The practice provided dedicated support to people at a local refugee centre.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as inadequate for providing safe and requires improvement for the provision of effective and well led services leading to the practice being rated as requires improvement overall. The issues identified impact on the care provided to this population group.

- The practice carried out advance care planning for patients living with dementia.
- 95% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is higher than the national average of 89%.
- The practice considered the physical health needs of patients with poor mental health and dementia.
- The practice did not have an effective system in place for monitoring repeat prescribing for patients receiving medicines for mental health needs. We found that there was not system in place for reviewing prescriptions that had not been collected which were issued. In one instance we found that a prescription which had not been collected had been reissued which created a risk that this patient would pick up their medication twice.
- Patients who suffered poor mental health who did not attend their appointment were followed up.

Summary of findings

- Performance in respect of mental health indicators was slightly higher than the local and national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- Staff told us that though they would not follow up patients who had attended accident and emergency where they may have been experiencing poor mental health they would review records an update care plans on the basis of information provided by secondary care services.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.
- One of the practice GPs provided a session each week to a local drug addiction service and the hosted a drug addiction counsellor.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages in most respects. Three hundred and sixty seven survey forms were distributed and ninety nine were returned. This represented 1.3% of the practice's patient list.

- 81% of patients described the overall experience of this GP practice as good compared with the CCG average of 79% and the national average of 85%.
- 73% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 73% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 73% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 38 comment cards. Twenty five of these were exclusively positive about the service received saying that they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Five of the comment cards contained negative feedback about the service experienced and eight contained feedback that included both positive and negative comments. Negative comments related to access to appointments and continuity of care.

We spoke with 10 patients during the inspection. All 10 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Negative feedback related to appointment access and continuity of care.

Sternhall Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and an Expert by Experience.

Background to Sternhall Lane Surgery

Sternhall Lane Surgery is part of Southwark Clinical Commissioning Group and serves approximately 5500 patients. The practice is registered with the CQC for the following regulated activities Surgical procedures; Family Planning; Maternity and Midwifery Services; Treatment of Disease, Disorder or Injury; Diagnostic and Screening Procedures.

The practice population has a slightly higher proportion of patients aged over 85 on their register and higher numbers of working age people compared to the national average.

The practice is located in an area which ranks within the third most deprived decile on the Index of Multiple Deprivation. The practice has almost three times the level of unemployment compared to the national average and lower levels of employment compared with local and national averages.

The practice is run by the Hurley Clinic Partnership. The practice looks after three care homes and has three GPs who provide ten clinical sessions to these homes each week. Additionally, one GP undertakes three GP sessions at a local refugee centre each week and one session within the practice. One of the GPs undertakes one session per week at a local detox facility.

Care for the practice's other patients is provided by five female GPs a practice nurse and a healthcare assistant.

The practice offers 24 sessions for these patients per week. Sixteen of these sessions are provided by permanent staff and eight are provided by locums.

The practice is open between 8am and 6.30pm Monday to Friday with the exception of Thursday and Friday when the practice opens from 7am. The practice offers booked and emergency appointments five days per week.

Sternhall Lane Surgery operates from a converted residential property which is sublet from the previous occupier of the GP practice who leases the premises from Southwark Council. The practice said that they were having difficulty determining who was responsible for building maintenance and upkeep and it was not clear if it was the Hurley Clinic Partnership or the previous GP who owned the practice who was responsible. The surgery is accessible to those with mobility problems.

Practice patients are directed to contact the local out of hour's provider when the surgery is closed.

The practice operates under a Personal Medical Services (PMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These are: Alcohol, Childhood Vaccination and Immunisation Scheme, Extended Hours Access, Facilitating Timely Diagnosis and Support for People with Dementia, Improving Patient Online Access, Influenza and Pneumococcal Immunisations, Minor Surgery, Patient Participation, Remote Care Monitoring, Rotavirus and Shingles Immunisation and Unplanned Admissions.

The practice is a member of the GP federation Southwark Independent Health Limited.

Detailed findings

Why we carried out this inspection

We carried out an announced comprehensive inspection at Sternhall Lane Surgery on 9 August 2016. The overall rating for the practice was requires improvement. The full comprehensive report from the inspection undertaken on 9 August 2016 can be found by selecting the 'all reports' link for Sternhall Lane Surgery on our website at www.cqc.org.uk.

As a result of our findings from this inspection CQC issued a requirement notice for the identified breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically we found concerns related to the management of emergencies, sufficient numbers of permanent clinical and administrative staff, training that had not been completed and the lack of action taken to mitigate risks identified.

We undertook a further announced comprehensive inspection of Sternhall Lane Surgery on 11 July 2017. This inspection was carried out to ensure improvements had been made.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England to share what they knew. We carried out an announced visit on 11 July 2017. During our visit we:

- Spoke with a range of staff (GPs, management both from within the practice and the wider Hurley Clinic Partnership, the practice nurse, the practice healthcare assistant and reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

At our previous inspection on 12 April; 2016, we rated the practice as requires improvement for providing safe services as:

- Not all significant events were discussed in practice meetings and there was one incident where staff provided inconsistent accounts of the learning outcome.
- Though searches were undertaken on receipt of safety alerts there was no documented evidence of action taken in response to patient safety alerts.
- Not all risks associated with infection control, fire and legionella had been mitigated.
- The processes around vaccine management were not effective and did not ensure these medicines were safe to use.
- Not all necessary recruitment checks had been completed for one staff member.
- There were insufficient permanent staff employed to carry out the regulated activity.
- The practice's oxygen servicing certificate had expired, there was not a full supply of emergency medicines and one member of clinical staff had not received basic life support training within the last 12 months.

Not all of these issues had been adequately addressed when we undertook a follow up inspection on 11 July 2017. For instance some staff we spoke with were unaware of the correct process for reporting significant events and could not recall learning from recent events. Infection control risks had not been assessed and not all staff had received training within the last 12 months. Prescriptions were not consistently being managed in a safe way. Though staff had received safeguarding training this was not to the level outlined in the practice's safeguarding policies. Old safeguarding policies with out of date information had not been archived. We found expired equipment with the practice's emergency supplies. Consequently the practice is now rated as inadequate for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events however it was evident that some staff were not aware of this system and that learning was not being effectively shared and embedded.

- The practice's policy for reporting significant events stated that all events should be reported using the practice's internal computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). However there were inconsistent accounts of how to report events. One staff member did not know how to report a significant event and thought that this would be documented in the patient record system. Another staff member told us that they would speak to a manager or a GP who would give them paperwork to complete. One clinical staff member and a non-clinical staff member told us that they were not involved in discussions around significant events. There had been 11 significant events within the last 12 months. Two clinical staff members we spoke with could only recall one event and a non-clinical staff member could not recall any.
- From the documented examples we reviewed we found that when things went wrong with care and treatment, patients received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. However we reviewed one significant event relating to one of the care homes the practice provided services to. This incident stemmed from May 2017 and we were told that this still had not been discussed.
- We saw evidence that action was taken to improve safety in the practice. For example, we reviewed one significant event related to a missed pathology result. The practice had implemented a system to ensure that all pathology results were reviewed in a timely manner by assigning a specific clinician to review pathology results each day.
- Significant events were reviewed at the corporate level in Hurley Clinic Partnership. Events that were

considered particularly serious or relevant were shared with the whole organisation via a newsletter. Staff at the practice said they found this was of limited use as it was not specific to incidents occurring within the practice.

Overview of safety systems and processes

The practice had defined and embedded systems, processes and practices in place to minimise risks to patient safety. Although the safeguarding lead was not currently working at the practice, interim arrangements were in place to ensure that safeguarding concerns were appropriately escalated. All staff had received safeguarding training in accordance with current legislation and guidance but not in accordance with the practice policy.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff though one staff member we spoke with was unable to access the policy. We also found out of date safeguarding policies in the practice's shared folder which contained out of date information. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice safeguarding lead noted in the policy was currently not working at the practice due to illness. All staff we spoke with said that they would refer to the practice manager in this staff member's absence. The practice manager confirmed that as there was no regular clinician available who worked every day, staff were to report any safeguarding concerns to her and she would delegate this to a clinician working that day. We were told that GPs would either attend safeguarding meetings when possible or provided reports where necessary for other agencies. We saw, after a period of time with no access to a local health visitor, regular meetings were now occurring between clinicians and the local health visitor team where vulnerable patients would be discussed.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. nurses to level 2 and the practice HCA and administrative staff to level 1. However the level of training was not in accordance with their local policy which stated that all staff required at least level 2 training. The practice informed us after the inspection that they had changed their policy to reflect change to CCG guidance which recommended that over a transitional period of three years all staff should be trained to at least level 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. The last infection control audit had been completed in February 2016. We saw a number of areas which had been raised in the audit which had not yet been addressed including damage to the roof in the practice manager's office and flooring and sinks which were not in line with current recommended guidance. We were told that the practice had not invested in these improvements as it was unclear who bore responsibility for addressing these issues and because the landlord had received planning permission to redevelop the site to include residential premises. The practice were not aware of when this would happen.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always ensure that patients were kept safe (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being issued to patients and there was a reliable process to ensure this occurred. However the practice did not have effective systems in place for reviewing uncollected prescriptions.

We found uncollected prescriptions dating back to October 2016. We reviewed seven of these and found that for one patient another prescription had been issued for medicine which had not been collected meaning that the patient could have potentially picked up twice the prescribed dose. For another patient, whose prescription had been issued in October 2016, the patient had been contacted and asked to attend the practice but had failed to attend. There had been no subsequent follow up. We saw that one vulnerable patient had a prescription issued by another healthcare organisation, this organisation had noted the dose incorrectly. The prescription had also not been signed. These issues had not been reviewed in line with the practice's significant event policy. We were told after the inspection that there was a policy for staff to review uncollected prescriptions but this would only occur every three to six months. It was acknowledged that some staff were not aware of this process.

- There were no documented checks of vaccine expiry dates though we were told that this would be checked when new vaccines were delivered. The practice carried out regular medicines reviews, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored but there were no systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Health care assistants were trained to administer vaccines and medicines and patient specific directions (PSDs) from a prescriber were produced appropriately (A PSD is a written instruction, signed by an authorised prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis).

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

The practice had a number of measures in place to monitor risks to patient safety and take mitigating action. However there were no documented fire drills.

- The practice had an up to date fire risk assessment and were told by several staff that fire drills were regularly carried out; although drills were not documented. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- There was a health and safety policy available.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. Most staff we spoke with said that the practice had sufficient numbers of clinical and non-clinical staff to meet patient needs and the practice had recently employed two salaried GPs. Staff at the practice informed us that recruitment and retention problems had been caused in part by locum positions both in the surgery and those offered by other services in the area being offered at higher rates of pay that salaried positions which disincentivised GPs from taking salaried positions.

Arrangements to deal with emergencies and major incidents

Inadequate

Are services safe?

The practice had arrangements to respond to emergencies and major incidents. Although the emergency equipment had been checked on a weekly basis we found an expired oxygen mask with the practice's oxygen cylinder.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Though staff at the practice undertook weekly checks of the emergency equipment we found an oxygen mask had expired in 2013. The practice nurse told us that they thought the expiry date was 2018. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our last inspection the practice was rated as good for providing effective services. However we recommended that the practice should:

- Review areas of high exception reporting including in relation to patients with chronic obstructive pulmonary disease, chronic kidney disease, atrial fibrillation, depression and osteoporosis consider strategies to improve patient outcomes by reducing exception reporting in those areas.
- Consider a system of internal appraisal for salaried GP staff.

We found on this inspection that the practice had not undertaken an analysis of higher exception reporting rates to assess whether the exclusions were clinically appropriate (though analysis was provided after our inspection) and no internal appraisals had been completed for GPs working at the practice in addition we found that rates of bowel and breast screening were lower than local and national averages, the practice had not achieved the national target in respect of one childhood immunisation and had completed only four out of 23 health checks for their learning disabled patients.

Effective needs assessment

Audits produced by the practice indicated that action would be taken in response to updated best practice guidelines issued from the local clinical commissioning group and National Institute for Health and Care Excellence (NICE). We saw no evidence that updates were discussed in clinical meetings. Staff said that the lead GP would cascade relevant information from NICE guidance by email and we saw evidence of one email sent by the lead GP which summarised the key points from a recent clinical update.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 94% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%.

The practice's overall exception reporting rate was 13% compared with the local average of 7% and the national average of 10% (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/16 showed:

- Performance for diabetes related indicators was mixed when compared to the CCG and national averages. For example the percentage of patients with well controlled blood sugar is 65% compared with 70% locally and 78% nationally. The practice provided unverified data for 2016/17 which showed that the practice had achieved 69% in this year which was in line with local and national averages. However the percentage of patients with well controlled blood cholesterol was 80% compared with the CCG average of 81% and 80% nationally.
- Performance for mental health related indicators was higher when compared with the CCG and national averages. For example the percentage of patients with complex mental health problems who had an agreed care plan recorded was 95% compared with 88% in the CC and 89% nationally. The percentage of these patients with a record of their alcohol consumption recorded in their notes was 93% compared with a local average of 86% and a national average of 90%.

  There were several indicators where the practice had exception reported higher percentages of patients compared to local and national averages in 2015/16. For example the exception reporting rate for patients with atrial fibrillation who met specific clinical criteria that had been treated with anticoagulation therapy was 35% compared with 10% locally and 11% nationally. The exception reporting rate of patients with chronic obstructive pulmonary disease with a record of an assessment of breathlessness was 39% compared with a local average of 6% and a national average of 12%. The exception reporting rate for patients with chronic obstructive pulmonary disease with a peak flow assessment was 40% compared with 6% locally and 16% nationally. The exception reporting rate of patients who had a current diagnosis of heart failure who had been treated with appropriate medication was 27% compared to 9% locally and 15% nationally. Finally the exception reporting rate of patients with a stroke or TIA

who have a record of a referral for further investigation between three months before or one month after the date of the latest recorded stroke or the first TIA was 32% compared with 6% locally and 8% nationally.

The practice said that there were a number of reasons for the level of exception reporting including that:

- They provided GP services to three care homes housing nursing and residential patients

  who were either on maximum tolerated doses of medication or were too ill or frail to participate in some of the required assessments.

- The practice had a high number of patients who were born in foreign countries that would spend considerable periods of time outside of the UK.
- Some patients had refused to attend for assessments and have treatment.
- Some of the patients exception reported were excluded for valid clinical reasons for example they were allergic to certain medicines or these were contraindicated.

We were provided with unverified exception reporting figures for each of the above areas for 2016/17 after our inspection. The exception reporting rate for patients with atrial fibrillation who qualified for anticoagulation therapy was 10%. We were told that anticoagulation therapy was contraindicated for all of the seven patients exception reported. All of these patients resided in one of the practice's care homes. The exception reporting rate of patients with chronic obstructive pulmonary disease with a record of an assessment of breathlessness was 21%. Of the 18 patients exception reported 16 of these patients resided in one of the care homes the practice provided support to and 14 of these had dementia, three of the patients were deemed too frail and one was under the care of a secondary care service. Only one of the 39 patients with heart failure had been exception reported as they were not suitable for participation in assessments. All patients who had a stroke had been referred to further investigation within three months before or one month after their last stroke meaning that no patients had been exception reported. This analysis of exception reporting data occurred after the inspection and it was evident that no review of the reasons for exception reporting had been undertaken prior to the inspection visit.

There was evidence of quality improvement including clinical audit:

- There had been four clinical audits commenced in the last two years, one of these was a single cycle, two were two cycle and one was a three cycle audit. The three cycle audit related to compliance with antibiotic prescribing guidelines. The audit demonstrated that between the first cycle and the second cycle. Compliance with the guidelines increased from 47% in the first cycle to 60% in the third cycle against a standard of 90%. The practice had also increased the proportion of patients with a respiratory tract infection whose notes reflected that antibiotic prescribing had been delayed or not prescribed had increased from 27% to 50%.
- The practice had also audited patients prescribed dipyridamole (medication that prevents blood clots from forming) as first-line therapy for secondary prevention post stroke or TIA (transient ischemic attack**)** as the preferred first line treatment in line with current guidelines is clopidogrel (used to reduce the risk of strokes). In the first cycle two patients were identified who had been prescribed dipyridamole both were moved to clopidogrel. At the second cycle the practice found that there were no patients prescribed dipyridamole which indicated that staff were continuing to prescribe in accordance with current guidelines.
- The practice had undertaken an audit of patients with atrial fibrillation (irregular heart rate) who were not prescribed anticoagulation therapy (blood thinning medication) to ensure that these patients had a documented assessment of their stroke and bleeding risk. At the first cycle the practice found that of the patients resident in one of the care homes the practice support, 63% had a documented stroke and bleeding risk assessment and of those patients who met the criteria who were not care home resident 67% had this assessment documented. At the second cycle the practice had increased this to 95% for care home residents and 100% of non-care home resident patients.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions and updates related to cancer and stroke prevention.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and local protected learning time events held within the locality.
- The learning needs of staff were identified through meetings, reviews of practice development needs and a system of appraisals for all staff excluding the doctors. While we saw that most staff had received an appraisal within the last 12 months. The practice did not provide internal appraisals for GPs.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

We were informed that documented clinical correspondence received by post or fax would be shared equally amongst all GPs working each day in addition GPs working for Hurley Clinic Partnership could access records remotely and review and progress correspondence from external organisations including pathology results. We saw evidence of care and risk assessments, care plans, medical records and investigation and test results.

- From the sample of examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

We saw through evidence of discussion with the district nursing team and minutes of meetings that the GP had with the care homes they supported that the practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- A dietician was available on the premises and smoking cessation advice was available from the practice healthcare assistant.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 77% and the national average of 81%.

Childhood immunisation rates for the vaccinations given were slightly lower when compared to the national target. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice achieved this target in three areas. In the other area the practice scored 84%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and that women who were referred as a result of abnormal results were followed up. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available.

The numbers of patients who were screened for breast and bowel cancer was lower than the local and national averages. The percentage of women screened for breast cancer in the last 36 months was 55% compared with 63% in the CCG and 73% nationally. The percentage of patients screened for bowel cancer within the last 30 months was 36% compared with 43% local and 58% nationally. Staff at the practice were aware of the comparatively low figures and told us that they would send letters to all patients who failed to attend for screening with details of how they could rebook their appointments. The practice said although clinical staff would promote the benefits of screening, patients had fed back that they did not want to participate in the screening programme as they found the prospect unpleasant. The practice also attributed the low uptake of screening to the higher levels of deprivation in the area among the practice population. The practice had 23 patients on their learning disabilities register. Only four of these patients had received a healthcheck within the last 12 months. The practice told us that invite letters were sent to these patients on five occasions within the last 12 months to encourage those with learning disabilities to attend for their healthcheck. The practice provided a copy of the letter sent to these patients. The letter was not in a format that would make it easy for those with learning disabilities to read.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

At our last inspection the practice was rated as good for providing caring services. However we recommended that the practice should improve the mechanisms for identifying those patients with caring responsibilities. We found at this inspection that the practice had increased the number of patients on their carers list from 42 (0.8%) to 61 (1%). The practice rating for caring remains good.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- There was no male GP working in the practice.

We received 38 patient Care Quality Commission comment cards. Twenty five of these were exclusively positive about the service received saying that they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Five of the comment cards we received were positive about the service experienced and eight contained feedback that included both positive and negative comments. Negative comments related to access to appointments and continuity of care.

We spoke with 10 patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Again the only negative comments related to access to appointments and continuity of care. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 84% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 89% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%
- 78% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local average of 81% national average of 85%.
- 89% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 91%.
- 88% of patients said the nurse gave them enough time compared with the CCG average of 86% and the national average of 92%.
- 97% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 94% and the national average of 97%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local average of 84% and the national average of 91%.
- 83% of patients said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed

decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Staff told us that they would treat children and young people in an age-appropriate way and recognised as individuals. Patient we spoke with on the day who were parents said that the practice prioritise same day appointments for children.

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

- 77% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 82% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the local average of 77% and the national average of 82%.
- 81% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 82% and the national average of 90%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the local average of 80% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (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.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 61 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. The healthcare assistant would direct carers to the local healthcare hub. All carers were offered an annual flu jab and older carers were offered timely and appropriate support.

Staff told us that if families had experienced bereavement a letter would be issued explaining the local bereavement service. These patients would also be offered support through referral to a local counselling service. Cards would also be issued to patients with details of the support that the GP surgery could offer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our last inspection the practice was rated as good for providing responsive services. However we recommended that the practice should advertise translation services in the reception area. We found on this inspection that information about translation services was now available. However we found on this inspection that the practice were not recording evidence of all complaint responses. The practice is rated as good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population: The practice supported a number of services in the CCG and dedicated clinical sessions and staff to focus on providing care and support to these services. For example the practice supported three nursing residential homes catering to approximately 400 people. The practice also held a session at a local detox clinic and provided three sessions per week at a local refugee centre.

- The practice offered extended hours on Thursday and Friday mornings between 7 am and 8 am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- The practice hosted a drug and alcohol counsellor.
- Working patients could upload their symptoms on a web template which would be reviewed by a clinician within 24 hours as an alternative to attending the surgery in person. The programme's algorithm was designed so that patients in need of emergency care and treatment would be directed to contact the emergency services.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. If there were no emergency appointments were available; children, vulnerable adults and those with complex needs would be triaged and offered appointments where appropriate. All other patients could be referred to the local extended hour's access hub which offered appointments from 8 am to 8 pm seven days per week.
- The practice sent text message reminders of appointments.
- Patients were not able to receive travel vaccines at the practice and were referred to a local service where these vaccines were available.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice hosted a dietician to support patients who needed advice on weight management including those with long term conditions.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday with the exception of Thursday and Fridays when the practice opened at 7am. Extended hours appointments were offered between 7 am and 8 am. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them. Results from the national GP patient survey showed that patient satisfaction scores relating to access was comparable to local and national averages in most areas.

- 63% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 87% of patients said they could get through easily to the practice by phone compared to the local average of 73% and the national average of 73%.
- 86% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 80% and the national average of 85%.
- 80% of patients said their last appointment was convenient compared with the CCG average of 86% and the national average of 92%.
- 73% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 50% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 46% and the national average of 58%.

In respect of the practice's opening hours the practice informed us that they did not offer late evening appointments for two reasons. Firstly the practice had undertaken a consultation with the PPG who had expressed a preference for early morning appointments. Secondly the practice had cited safety as a concern and had said that there had been several attacks on the street where the practice was located and that staff and patients would not feel safe leaving or entering the premises after dark.

We reviewed the practice's appointment system which showed that the next available appointment with a GP was on 13 July 2017. However patients told us on the day of the inspection that they were not easily able to get an appointment when they needed them. This appeared to stem from the patients' desire to see a preferred clinician which could result in a delay of three weeks or more. The practice had recently recruited two permanent full time GPs and it was hoped that this would improve continuity of care for patients.

The practice had a system to assess:

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

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. However we saw that this had not been followed for all complaints.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. The policy was clearly displayed in the practice waiting area.

We looked at four of the eight complaints received in the last 12 months and found that these were mostly satisfactorily handled. However for one complaint we found that the complainant had sent two subsequent responses to the practice. Staff at the practice informed us that they had contacted the patient by telephone and resolved the complaint. However there was no documented response. None of the complaints reviewed provided patients with the contact information for external organisations that patients could escalate complaints to if they were unhappy with the practice's response. Lessons were learned from individual concerns and complaints and action was taken to as a result to improve the quality of care. For example, the practice had received complaints regarding staff retention and the use of locum GPs. As a result Hurley Clinic Partnership had changed their recruitment process to ensure that adverts were site specific and had recruited two salaried GPs in an effort to improve continuity of care.

Are services well-led?

Requires improvement

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

Our findings

At the last inspection the practice was rated as requires improvement for the key question: Are services well led? This is because there were deficiencies in governance around risk management including infection control, fire and legionella and there was little evidence of quality improvement. At this inspection we found that the practice had addressed a number of the issues raised at the last inspection. There was evidence of quality improvement and action had been taken in response to risk assessments. However we identified new concerns related to risk management and patient safety.

Vision and strategy

The practice aimed to deliver high quality care and had recruited additional staff since our previous inspection to improve the consistency of service and continuity of care. However we found that systems and processes to ensure that patients were kept safe did not always operate effectively and impeded on the practice's ability to deliver their vision.

- The practice had completed an action plan with the support of NHS England on the basis of the last inspection.
- Business planning for the practice had been impeded by the prospect of the site being redeveloped. Staff at the practice were able to outline possible options under consideration to ensure that the service would continue to function if and when the redevelopment proceeded.

Governance arrangements

The practice's governance framework did not operate effectively in a number of key areas including in respect of the identification and mitigation of risk, effective systems and processes and that information was not always shared effectively to enable learning from significant events. This impacted on the practice's ability provide good quality safe care.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. The practice nurse led in chronic disease management and infection control. Although there was a lack of practice level clinical leadership in some areas due to staff absences, the practice manager taken over this leadership role and would cascade information to the clinicians working that day. For example all staff were aware that safeguarding matters should be reported to the practice manager in the lead's absence who would pass the matter to a clinician working that day to be reviewed escalated where appropriate. We were told that support was being offered from the partners within Hurley Clinic Partnership.
- The practice had policies and procedures to govern most activities within the practice yet it was evident that there were some areas in which governance and oversight were lacking; for example in the management of medicines. Though the practice had a range of policies to govern activity stored on their shared drive there were areas where policy frameworks did not always operate effectively; for example in the management of significant events. One member of staff we spoke with could not locate the practice's safeguarding policy and we found a safeguarding policy on the shared drive with out of date information. Though systems were in place for checking the expiration date of emergency equipment we found an expired paediatric oxygen mask.
- Practice and clinical meetings were regularly scheduled but we were told that due to staff shift patterns or other commitments these would not always happen. Staff who were unable to attend meetings could access minutes of meetings on the practice's shared drive though staff at the practice told us that it was difficult to share and embed learning and communicate effectively due to clinical staff working patterns and time constraints which prevent staff from reviewing minutes from meetings.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Not all risks had been adequately assessed or mitigated including those associated with infection control and the management of medicines.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. However from speaking to staff it was evident that this information was not always cascaded or learning embedded.

Leadership and culture

Staff told us the GPs and management were approachable and always took the time to listen to all members of staff.

Are services well-led?

Requires improvement

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

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

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence in respect of incident which feel under the duty of candor.

There was a leadership structure in place and staff knew who to raise concerns with. Staff felt supported by management but information and discussions held were not always disseminated in a way that meant staff were always aware of what was happening in the practice.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and staff from the services that they supported. Staff had regular meetings with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings but due to the working patterns of staff it was difficult to arrange meetings at a time when all staff were available. Minutes were taken at meetings and kept with the practice manager but evidence from discussions with staff showed that there was limited awareness of outcomes from meetings among staff who did to attend.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at any time and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the practice manager. We were told that all clinical staff were approachable and the team worked well together. Clinical staff told us that the administrative team provided excellent support.
- All staff had access to a support service offered by The Hurley Clinic Partnership. This was a confidential service which provided information and advice on a wide range of matters including housing, benefits, careers as well counselling.
- Staff who were able to attend practice meetings were involved in discussions about how to run and develop the practice. Management at the practice welcomed ideas that staff had for making improvements.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice had discussed with the PPG and consulted with patients about their extended hour's access. The practice offered appointments between 7 am and 8 am Thursdays and Fridays as patients had expressed a preference for early morning appointments over appointments later in the evening.
- The NHS Friends and Family test, complaints and compliments received.
- Staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement within the Hurley Clinic Partnership. The practice had developed systems including the e-consultation service. This computer programme enabled patients to upload symptoms into the practice's online system and be provided with either self-care advice or clinical advice from GPs working remotely.

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 **How the regulation was not being met:** Governance systems and processes were not in place to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk including staff. Specifically in respect of systems and processes related to significant event management, medicines management, infection control, safeguarding and complaints. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Warning notice** **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. They had not assessed risks associated with infection control within the last twelve months, the management of medicines did not ensure that patients were kept safe . This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations