The Pinner Road Surgery

Inspection report

196 Pinner Road
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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 location	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This practice is rated as requires improvement overall.

The key questions are rated as:

Are services safe? - Requires improvement

Are services effective? - Good

Are services caring? - Good

Are services responsive? - Good

Are services well-led? - Requires improvement

We carried out an announced comprehensive inspection at The Pinner Road Surgery on 14 May 2018. We carried out this inspection 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 Pinner Road Surgery was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

At this inspection we found:

- We noted the current provider had inherited the number of challenges when they took over the practice in August 2017. We found the practice had implemented the number of measures to mitigate the challenges.
- There was a lack of good governance in some areas.
- Risks to patients were assessed and well managed in some areas, with the exception of those relating to fire safety, staff vaccination and management of blank prescription forms.
- The practice was unable to provide documentary evidence to demonstrate that all staff had received training relevant to their role.
- The practice was unable to demonstrate that all appropriate recruitment checks had been undertaken prior to employment.
- The practice had not provided curtains in all consulting/ treatment rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Information about services and how to complain were available and easy to understand.
- The practice was aware of and complied with the requirements of the Duty of Candour.
- Staff we spoke with informed us the management was approachable and always took time to listen to all members of staff.

The areas where the provider **must** make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Review the management and security of blank prescription forms, to ensure this is in accordance with national guidance.
- Implement a system to ensure the effective monitoring of uncollected prescriptions.
- Ensure all staff have received formal training relevant to their role including sepsis awareness training.
- Ensure all actions required in response to legionella risk assessment are completed in a timely manner.
- Ensure information about a translation service is displayed in the reception area informing patients this service is available. Ensure information posters and leaflets are available in multiple languages.
- Ensure curtains are provided in all consulting and treatment rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector**.**
The team included a GP specialist adviser.

Background to The Pinner Road Surgery

- The Pinner Road Surgery is a GP practice located in West Harrow in North West London and is part of the Harrow Clinical Commissioning Group (CCG). The practice is located in converted premises.
- Services are provided from: 196 Pinner Road, West Harrow, Middlesex, HA1 4JS.
- Online services can be accessed from the practice website: www.pinnerroadsurgery.co.uk.
- Out of hours (OOH) service is provided by the Care UK.
- There is one principal GP and two salaried GPs at the practice. Two GPs are female and a male, who work a total of 15 sessions per week. The practice employs a practice nurse, a student nurse, a physician associate (who works one day per week under the supervision of the GPs), a clinical pharmacist, a phlebotomist and a health care assistant. The CCG employs an enhanced practice nurse who works two days per week at the practice. The principal GP is supported by a team of administrative and reception staff. The practice had engaged a firm of practice management consultants to provide practice management support.
- The principal GP has joined the practice as one of the partners in June 2016 and subsequently registered with the CQC as an individual in August 2017 after the retirement of previous partners.
- The practice provides primary medical services through a Primary Medical Services (PMS) contract to approximately 4,020 patients in the local area (PMS contracts are negotiated locally between GP representatives and the local office of NHS England).
- Ethnicity based on demographics collected in the 2011 census shows the patient population is ethnically diverse and 57% of the population is composed of patients with an Asian, Black, mixed or other non-white backgrounds.
- The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury and maternity and midwifery services.

Requires improvement

Are services safe?

We rated the practice as requires improvement for providing safe services.

The practice was rated as requires improvement for providing safe services because:

- The practice was unable to produce evidence that all staff had received up-to-date safeguarding and safety training appropriate to their role.
- The practice had not always carried out appropriate staff checks at the time of recruitment.
- The practice was unable to provide documentary evidence that staff vaccination was maintained in line with current Public Health Guidance (PHE) guidance.
- Fire safety risk assessment was out of date and the practice was unable to demonstrate that all actions required in response to current fire safety risk assessment were completed in a timely manner to address the risks identified in the risk assessment.
- Blank prescription forms for use in printers were not handled in accordance with national guidance as these were stored in unlocked printers in unlocked consulting rooms and these were not locked away at night from the printers.

Safety systems and processes

The practice had some systems to keep people safe and safeguarded from abuse, and improvements were required.

- The practice had some systems to safeguard children and vulnerable adults from abuse. Staff we spoke with knew how to identify and report concerns. However, the practice was unable to produce evidence that all staff had received up-to-date safeguarding and safety training appropriate to their role. For example, a clinical staff member and three administrative staff had not completed safeguarding children training. Two clinical staff had not completed adult safeguarding training.
- Reports and learning from safeguarding incidents were available to staff. All administrative staff who acted as chaperones were formally trained for their role. Most staff had received a DBS check with the exception of a clinical staff member. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The four staff files we reviewed showed that appropriate recruitment checks had not been undertaken prior to employment for most staff. For example, Disclosure and Barring Service (DBS) checks, proof of identification and address, references, qualifications, health checks (satisfactory information about any physical or mental health conditions) and entitlement to work in the UK were not available.
- The practice was unable to provide documentary evidence that staff vaccination was maintained in line with current Public Health Guidance (PHE) guidance.
- There was an effective system to manage infection prevention and control. The practice had carried out an infection control audit and they had developed an action plan to address the risks identified in the audit. However, the action plan did not include the time scale to complete the recommended actions. The provider was unable to provide documentary evidence that a clinical staff member and four administrative staff had completed infection control training.
- The practice had arrangements to ensure that equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections

including sepsis. Some non-clinical staff we spoke with were not sure how to identify symptoms of sepsis in an acutely unwell patient. Staff had not completed formal sepsis awareness training.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines with the exception of management of blank prescription forms.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- On the day of the inspection, we saw there was a system in place to monitor the use of blank prescription forms for use in printers, and these were recorded and tracked through the practice at all times. However, we found blank prescription forms for use in printers were stored in unlocked printers in unlocked consulting rooms and these were not locked away at night from the printers.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a track record on safety. However, improvements were required.

- A fire safety risk assessment had been carried out by an external contractor on 14 March 2017. According to this fire safety risk assessment it was required to undertake a review after 12 months, however this action had not been carried out. The fire risk assessment had identified a number of high risk areas and recommended actions to ensure fire safety in the premises. On the day of inspection, the practice was unable to demonstrate that all actions required in response to current fire safety risk assessment were completed in a timely manner to address the risks identified in the risk assessment.
- For example, the electronic fire detection and alarm system was not installed at the premises. However, the practice had installed a number of battery operated smoke alarms in the premises and was carrying out regular smoke alarm checks.
- Emergency lighting was not installed at the premises.
- The rear fire exit door was not fitted with a push bar system. The practice informed us their plans to improve disabled access through the rear fire exit had been delayed. There was no documented fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- The practice informed us few days after the inspection that they had booked an external contractor's visit to undertake a fire safety risk assessment, a legionella risk assessment, Disabled Access Audit or Disability Discrimination Act (DDA) Audit, and health and safety audit of the premises in June 2018. The practice informed us they were going to replace the rear fire exit door in June 2018.
- The practice had carried out a variety of other checks to monitor the safety of the premises such as gas safety checks and the fixed electrical installation checks of the premises. However, the practice was unable to provide documentary evidence of control of substances hazardous to health (COSHH) risk assessment and an asbestos survey was not carried out.
- A Legionella (a bacterium which can contaminate water systems in buildings) risk assessment was carried out on 31 May 2017. The practice was carrying out regular water temperature checks as recommended in the risk assessment. However, they were not recording the actual dates of the checks. The risk assessment did not include the name of the responsible person. The practice was unable to demonstrate that all actions required in response to legionella risk assessment were

completed in a timely manner to address the risks identified in the risk assessment. The practice was unable to provide documentary evidence that the responsible person had completed the relevant training.
- The practice was not able to provide documentary evidence that two GPs, a practice nurse, a phlebotomist and five administrative staff had completed health and safety training.
- The practice was not able to provide documentary evidence that a GP, a practice nurse, a phlebotomist and two administrative staff had completed fire safety training.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice as good for providing effective services overall and across all population groups.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.*)*

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had completed 32 care plans.
- The practice followed up on older patients discharged from the hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in the hospital or through out of hours services.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

The current provider had taken over the new contract to run the practice in August 2017, five months into the 2017/18 QOF year. These results had not been published yet but the practice had provided us unverified data for the QOF year 2017/18. The overall performance for various indicators (of unverified QOF 2017/18 results) relating to the long-term conditions was satisfactory and demonstrated improvements compared to the previously published QOF results (of 2016/17). For example,

- The percentage of patients with diabetes, on the register, in whom the last HbA1c is 64 mmol/mol or less in the preceding 12 months (2016/17) was 71% (CCG average 80%; national average 80%) with an exception reporting of 1% (CCG 8%; national 12%). However, we noted in 2017/18 (unverified QOF data), the practice performance for this indicator was 85%. This was a 14% increase from the 2016/17 QOF data.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 63% (CCG average 77%; national average 76%) with an exception reporting of 4% (CCG average 4%; national average 8%). However, we noted in 2017/18 (unverified QOF data), the practice performance for this indicator was 84%. This was a 21% increase from the 2016/17 QOF data.

Good

Are services effective?

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% for one out of four immunisations measured (in 2016/17) for children under two years of age. On the day of the inspection, the practice provided recent data (January 2018) which demonstrated they had achieved overall 90% target for children under two years of age. The practice had an effective recall system in place for child immunisation.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 56%, which was below the 80% coverage target for the national screening programme. The practice had taken steps to promote the benefits of cervical screening in order to increase patient uptake. The practice had advertised the relevant information on their website and displayed on the notice boards in the waiting area encouraging patients to take part in the national cancer screening programme. According to 2017/18 QOF data (unverified), the practice performance for the uptake for cervical screening was 68%. This was a 12% increase from the 2016/17 data (Public Health England).
- The practices' uptake for breast and bowel cancer screening was comparable to the national average. In total 47% of patients eligible had undertaken bowel cancer screening and 71% of patients eligible had been screened for breast cancer, compared to the national averages of 55% and 70% respectively.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Data from 2016/17 showed performance for dementia face to face reviews was above the CCG average and national average. The practice had achieved 100% of the total number of points available, compared to 89% locally and 84% nationally. Exception reporting was 7%, compared to the CCG average of 5% and the national average of 7%.
- According to the data from 2016/17, 52% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was below the CCG average (91%) and national average (90%). However, we noted in 2017/18 (unverified QOF data), the practice performance for this indicator was 98%. This was a 46% increase from the 2016/17 QOF data.

Good

Are services effective?

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, according to the data from 2016/17, 64% of patients experiencing poor mental health had received discussion and advice about alcohol consumption, compared to 92% locally and 91% nationally. However, we noted in 2017/18 (unverified QOF data), the practice performance for this indicator was 96%. This was a 32% increase from the 2016/17 QOF data.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The most recent published Quality Outcome Framework (QOF) results for the period 1 April 2016 to 31 March 2017 were 84% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and the national average of 97%. The overall clinical exception reporting rate was 6% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

The current provider had taken over the new contract to run the practice in August 2017 and informed us they had implemented a number of changes with the aim of improving the clinical outcomes. The practice demonstrated its current achievement from its clinical system and an overview of how it was addressing the clinical areas where improvement had been identified. The practice informed us they had achieved 95% (529) of the total number of points available (559) in the QOF year 2017/18 (unverified QOF data). The practice had demonstrated improvements compared to the previously published QOF results for 2016/17. For example,

- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 73% (CCG average 81%; national average 80%) with an exception reporting of 6% (CCG average 9%; national 13%). However, we noted in 2017/18 (unverified QOF data), the practice performance for this indicator was 79%. This was a 6% increase from the 2016/17 QOF data.

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- There had been three clinical audits commenced in the last one year, two of these were completed audits where the improvements made were implemented and monitored.
- The practice used information about care and treatment to make improvements. For example, we saw evidence of repeated audit cycle of type 2 diabetic patients on two or more oral antidiabetic medicines with HbA1c > 58 mmol/mol (an indicator to measure blood sugar level). The aim of the audit was to identify and review the treatment to ensure effective management of blood glucose levels to prevent progression to serious complications. The first audit in November 2017 demonstrated that 76% of patients were taking two or more oral antidiabetic medicines with HbA1c > 58 mmol/mol. The practice offered an advanced diabetes training course to staff members, focussing on supporting patients with type 2 diabetes. The practice invited every diabetic patient with HbA1c > 58 mmol/mol for a review and discussed the suitability for future treatment, and insulin therapy was discussed as an option to better manage their diabetes. The practice had identified 39 out of 76 patients who could be potentially good candidates for insulin therapy. The practice had reviewed the treatment as appropriate, and a follow-up audit carried out in May 2018 demonstrated improvements in patient outcomes and found 62% of patients were taking two or more oral antidiabetic medicines with HbA1c > 58 mmol/mol. This was a 14% reduction in the number of patients taking two oral antidiabetic medicines with HbA1c > 58 mmol/mol.

The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had recruited a clinical pharmacist who was working closely with the medicine optimisation team and significantly improved the prescribing performance. Such as;

Good

Are services effective?

- Performance for the daily rate of prescribing (items prescribed per Specific Therapeutic prescribing data) of all antibacterial medicines was 0.54 in January 2018. The practice had demonstrated significant improvement, because the practice performance for the above indicator was 0.88 in March 2017. This was a 0.34 reduction from the previous data.
- Performance for the percentage of antibiotic medicines prescribed that were Co-Amoxiclav (used to treat bacterial infections), Cephalosporins (usually prescribed for patients undergoing dialysis) or Quinolones (used to treat infections) was 6% in January 2018. The practice had demonstrated significant improvement, because the practice performance for the above indicator was 16% in March 2017. This was a 10% reduction from the previous data.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, the practice was unable to provide documentary evidence to demonstrate that all staff had completed training relevant to their role.

- Some staff had not received training that included: safeguarding children and adults, infection control, fire safety, health and safety, Mental Capacity Act 2005, and equality and diversity. Staff had access to and made use of e-learning training modules and in-house training.
- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from the hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.

Good

Are services effective?

- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Results from the national GP patient survey (published in July 2017) showed less patients felt they were treated with compassion, dignity and respect. The practice was below the clinical commissioning group (CCG) average and the national average for most of its satisfaction scores on consultations with GPs and nurses.
- The practice was aware of poor national survey results and informed us that the national GP patient survey data was collected during the period 1 January 2017 to 31 March 2017 and the current provider took over the new contract in August 2017. The practice informed us they had analysed the survey results, implemented a number of changes and with staffing issues stabilising, they were expecting better results in the surveys conducted in the future. However, recent survey results were not published and it was not possible to assess the impact of changes introduced by the new provider.
- All but one of the 32 patient Care Quality Commission comment cards we received were positive about the service experienced. A patient and a member of the patient participation group (PPG) we spoke with were also happy with the service. Patients providing positive feedback said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.
- We noted the NHS friends and family test (FFT) results for last seven months (covering the period October 2017 to April 2018) and 77% patients were likely or extremely likely recommending this practice. We reviewed the graphical analysis of the FFT results for last 12 months and noted that the satisfaction levels had been gradually increased since October 2017 onwards.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Interpretation services were available for patients who did not have English as a first language. However, we did not see notices in the reception area, including in languages other than English, informing patients this service was available.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- Results from the national GP patient survey (published in July 2017) showed patients responded less positively to questions regarding GPs and nurses about their involvement in planning and making decisions about their care and treatment. However, recent survey results were not published and it was not possible to assess the impact of changes introduced by the new provider since August 2017.
- Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.
- Feedback from patients was positive and reflected that the clinicians had involved them in decisions about their care and treated them with care and concern.

Privacy and dignity

The practice respected patients' privacy and dignity, however improvements were required.

- Curtains were not provided in one consulting room and one treatment room to maintain patients' privacy and dignity during examinations, investigations and treatments. However, the practice informed us few days after the inspection that they were going to install the curtains in all the consulting/ treatment rooms.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

Good

Are services caring?

- 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.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice was proactive in offering online services, which included online appointment booking; an electronic prescription service and online registration.
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice had secured funding to extend the premises with more space and additional consulting rooms.
- The practice made reasonable adjustments when patients found it hard to access services. For example, there were accessible facilities, which included a hearing loop, a disabled toilet and baby changing facility.
- The facilities and premises were appropriate for the services delivered. The new provider informed us they had carried out internal and external renovation of the premises to address the issues related to the infection control and health and safety.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice website was well designed, clear and simple to use featuring regularly updated information. The practice website included a translation facility.
- The practice sent text message reminders of appointments.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- A dedicated enhanced practice nurse (EPN) was employed by the CCG (working for four local practices including two days at this practice) who was offering a holistic health and social care service to all housebound patients. Patients who required additional support were referred to the social services or other health care professionals where more intensive support was available.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group 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, the practice offered extended opening hours every Friday from 6.30pm to 7.30pm. First appointment with a GP was available from 8am Monday to Friday.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

Good

Are services responsive to people's needs?

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Pre-bookable appointments could be booked up to four weeks in advance.
- Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable or below the local and national averages. The practice had analysed the survey results and took steps to improve the access to care and treatment. For example,
- The practice had recruited a salaried GP in August 2017, a clinical pharmacist in December 2017, a physician associate in January 2018 and a trainee practice nurse in February 2018.
- The practice had increased the number of GP sessions since August 2017. The practice was planning to increase the working hours of a physician associate from one to two days per week with a view to offer a full-time contract in the future.
- The practice had recruited a new practice manager and a new receptionist in December 2017. The practice was in the process of recruiting a new reception/ administrative staff to ensure sufficient staff were available to answer the telephone calls during the peak hours. The practice was planning to recruit a part time practice nurse.
- The practice was planning to change the telephone system and increased the number of telephone lines. The practice was seeking advice to terminate the long-term telephone contract they had inherited from the previous provider.
- However, recent survey results were not published and it was not possible to fully assess the impact of changes introduced by the new provider.
- The practice was encouraging patients to register for online services and 12% patients were registered to use online services.
- We checked the online appointment records and noted that the next pre-bookable appointments with named GP was available within one to two weeks. We noted that the next pre-bookable appointment with any GP was available within one week. Urgent appointments with GPs or nurses were available the same day.
- Feedback from patients was positive and reflected that patients were satisfied with appointment booking system and were able to get appointments when they needed them. A member of the patient participation group (PPG) we spoke with was also happy with the access to the service.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the practice had installed new CCTV cameras and signage to address the anti-social behaviour issues in the practice car park.

Please refer to the Evidence Tables for further information.

Requires improvement

Are services well-led?

We rated the practice and all of the population groups as requires improvement for providing a well-led service.

The practice was rated as requires improvement for well-led because:

- There was a lack of good governance in some areas.
- The practice had not assured that all policies and procedures were up to date.
- The practice was unable to demonstrate that the feedback from patients through the patient participation group (PPG) was sought and acted upon.

Leadership capacity and capability

The principal GP had the capacity and skills to deliver high-quality, sustainable care.

- The principal GP was knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. The principal GP was splitting their time between two practices. The principal GP was offering three clinical sessions at the practice and allocated two sessions for administration and management of the service.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had recruited a new practice manager in December 2017. The practice informed us on the day of inspection that a firm of practice management consultants was still working with the practice and providing support to the new practice manager. However, the principal GP informed us a week after the inspection that the new practice manager had left the practice and they were responding to recent management changes.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice had secured funding for an extension to the premises. It had ambitions to expand the range of services available to the local population and to become a teaching and training practice.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- The principal GP acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

The practice had a governance framework, however, improvements were required. For example:

Requires improvement

Are services well-led?

- We noted the current provider had inherited the number of challenges when they took over the practice. We found the practice had implemented the number of measures to mitigate the challenges and shown improvements. However, they were required to make further improvements.
- A firm of practice management consultants had worked alongside the practice in implementing the changes and it was too early to evaluate whether the changes made would be sustainable and deliver consistent and appropriate governance of the practice.
- There was no formal monitoring system for following up patients experiencing poor mental health and patients with dementia who failed to collect their prescriptions in a timely manner. On the day of the inspection, we found 21 prescriptions dated back to July 2017 which were not collected. However, none of them was for patients experiencing poor mental health and patients with dementia.
- Practice specific policies were available to staff. However, some policies did not include the name of the author and they were not dated so it was not clear when they were written or when they had been reviewed. We noted some policies were not comprehensive and did not include appropriate details.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

Managing risks, issues and performance

There were processes in place for managing risks, issues and performance.

- There were processes to identify, understand, monitor and address current and future risks including risks to patient safety. However, some risks related to fire safety, recruitment checks, management of legionella and staff vaccination were not always managed appropriately.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services. However, some improvements were required.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. However, they did not have an active patient participation group (PPG). The practice had recently appointed a PPG chair and there was no evidence available to demonstrate that the practice had collected any feedback through

Requires improvement

Are services well-led?

the PPG. The practice informed us they were planning to develop the PPG and encouraging patients to join and attend patient participation group (PPG) in order to collect constructive feedback.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:The fire safety risk assessment was out of date and the practice was unable to demonstrate that all actions required in response to fire safety risk assessment were completed in a timely manner to address the risks identified in the risk assessments. The practice was unable to provide documentary evidence of control of substances hazardous to health (COSHH) risk assessments and an asbestos survey was not carried out. The provider was unable to provide documentary evidence that staff vaccination was maintained in line with current Public Health Guidance (PHE) guidance. The practice was unable to produce evidence that all staff had received up-to-date safeguarding and safety training appropriate to their role.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:There was a lack of good governance in some areas and we found breaches of regulation that had not been identified by the practice prior to inspection, which demonstrated that governance monitoring procedures were not always carried out consistently and effectively.The practice had not assured that all policies

This section is primarily information for the provider

Requirement notices

and procedures were up to date.The practice was unable to demonstrate that the feedback from patients through the patient participation group (PPG) was sought and acted upon.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:The practice had not always carried out appropriate staff checks at the time of recruitment and on an ongoing basis. For example, Disclosure and Barring Service (DBS) checks, proof of identification and address, references, qualifications, health checks (satisfactory information about any physical or mental health conditions) and entitlement to work in the UK were not available for most staff.