

Dr Hugh Wright

Quality Report

40 Biddulph Mansions
210 Elgin Avenue
London W9 1HT
Tel: 020 7286 6464
Website: www.mvmc.co.uk

Date of inspection visit: 15 October 2015
Date of publication: 21/01/2016

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

Ratings

Overall rating for this service

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Requires improvement 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Hugh Wright on 15 October 2015. Overall the practice is rated as requires improvement.

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.

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

- Arrangements were in place to ensure patients were kept safe. For example, staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses
- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice guidance.

- We saw from our observations and heard from patients that they were treated with dignity and respect and all practice staff were compassionate.
- The practice understood the needs of their patients and was responsive to them. There was evidence of continuity of care and people were able to get urgent appointments on the same day.
- There was a culture of learning and staff felt supported and could give feedback and discuss any concerns or issues with colleagues and management

However, there were also areas of practice where the provider must make improvements:

Action the provider must take to improve:

- The practice should develop a clear vision and strategy to deliver high quality care and promote good outcomes for patients and ensure all staff are aware of it.
- Ensure clinical audits are undertaken in the practice, including completed clinical audit or quality improvement cycles.

Summary of findings

- Ensure an up to date environmental risk assessments is carried out and risks are regularly monitored.
- Ensure an up to date infection control audit is undertaken.
- The practice should ensure an automated external defibrillator (used to attempt to restart a person's heart in an emergency) is available or should carry out a risk assessment to identify what action would be taken in an emergency.

Action the provider SHOULD take to improve

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. There was an effective system in place for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored and addressed. However, we found the last practice environmental risk assessment and infection control audit was carried out in 2011.

Requires improvement



Are services effective?

The practice is rated as good for providing effective care. Data showed patient outcomes were average or above for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams. However, there was no evidence that audit was driving improvement in performance to improve patient outcomes as the practice had not completed any clinical audits in the last twelve months.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a named GP and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. However, the premises were not easily accessible to patients with disabilities. There were a number of steps down to the reception and waiting

Good



Summary of findings

area. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as requires improvement for being well-led. There was a documented leadership structure and staff felt supported by management. However, it did not have a clear vision and strategy, and staff we spoke with were not clear about the practice values. We were told the practice held weekly governance meetings which were attended by the lead GP and the practice manager however; there were no minutes available for us to confirm this. Staff told us QOF data was regularly reviewed and discussed at the practices monthly meetings. However, the practice did not have any completed clinical audits in the last 12 months. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review.

Requires improvement



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits to patients that were housebound. There was a care navigator based at the practice one day a week. There was a register for older people who have complex needs, required additional support or were housebound and care plans were in place to ensure these patients and their families receive coordinated care and support.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the care of people with long-term conditions. Clinical staff had lead roles in chronic disease management and patients. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies although it was difficult to access the surgery with a pushchair due to the steps leading to the entrance. We saw good examples of joint working with health visitors.

Requires improvement



Working age people (including those recently retired and students)

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and

Requires improvement



Summary of findings

students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They had a primary care liaison nurse for mental health, a counsellor and CBT psychologist based at the practice one day a week

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as MIND and Improving Access to Psychological Therapies (IAPT).

Staff had a good understanding of how to support people with mental health needs and dementia. They ran Dementia Awareness workshops organised in the practice in conjunction with the CCG Dementia Specialist. They also carried out advance care planning for patients with dementia and scored 100% on their dementia QOF scores.

Requires improvement



Summary of findings

What people who use the service say

We spoke with 5 patients during our inspection and received 18 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were positive about the practice.

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Patients said all staff were courteous, helpful, professional and treated them with dignity and respect. However, some patients told us they felt rushed and not listened to by one GP at the practice and had refused to see that particular GP on occasions.

Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and that most GPs gave consistently good care.

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 99 responses and a response rate of 21%

- 95% found it easy to get through to this surgery by phone compared to a CCG average of 82% and a national average of 75%.
- 86% found the receptionists at this surgery helpful compared to CCG average of 82% and a national average 82%
- 87% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average 82% and a national average 85%
- 79% said the last appointment they got was convenient compared to a CCG average 87% and a national average 92%.
- 74% described their experience of making an appointment as good compared to a CCG average 71% and a national average 73%.
- 60% usually waited 15 minutes or less after their appointment time to be seen (CCG average 57%, national average 65%).

Areas for improvement

Action the service **MUST** take to improve

- The practice should develop a clear vision and strategy to deliver high quality care and promote good outcomes for patients and ensure all staff are aware of it.
- Ensure clinical audits are undertaken in the practice, including completed clinical audit or quality improvement cycles.
- Ensure an up to date environmental risk assessments is carried out and risks are regularly monitored.

- Ensure an up to date infection control audit is undertaken

Action the service **SHOULD** take to improve

- The practice should ensure an automated external defibrillator (used to attempt to restart a person's heart in an emergency) is available or should carry out a risk assessment to identify what action would be taken in an emergency.

Dr Hugh Wright

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and two CQC inspectors.

Background to Dr Hugh Wright

Dr Hugh Wright provides GP primary care services to approximately 7000 people living in Maida Vale, North West London. The practice is staffed by three GPs, two male and one female who work a combination of full and part time hours. The practice employs one nurse, a practice manager and five administrative staff. The practice holds a General Medical Services (GMS) contract and was commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are 8.30am to 6.00pm Mondays, 8.30am to 7.40pm Tuesdays, 8.30am to 1pm on Wednesday, 8.30am to 8.30pm on Thursdays and 8.30am to 5pm on Friday. The out of hours services are provided by an alternative provider. The details of the 'out of hours' service are communicated in a recorded message accessed by calling the practice when closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

The practice provides a wide range of services including clinics for child health care and smoking cessation. The practice also provides health promotion services including a flu vaccination programme, travel vaccinations and cervical screening.

The practice is located in an area where the population is relatively young with approximately 65% residents under 50 years of age. The population is ethnically diverse.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

- Older people

Detailed findings

- People with long term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations

such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 15 October 2015. During our visit we spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Administrative staff and receptionists told us they would inform the practice manager and complete the incident templates that were available on the practice computer. These were usually discussed on the day they occurred and always discussed at the monthly practice meeting. We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw there had been a recent incident where the wrong patient was referred to the hospital due to having a very similar name. The practice immediately implemented a double checking process of asking for the patient's first name and surname and date of birth. All staff were advised of the change and why.

The practice sent an analysis of the significant events (SEA) annually to the CCG, which included identifying any themes and learning points.

National patient safety alerts were disseminated by the practice manager to the relevant practice staff by email through the practices computer system messaging facility. Staff we spoke with told us of recent alerts they had discussed regarding deaths linked to a particular drug.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard patients from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.
- A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone, administration staff had been asked

to carry out this role. We were told that chaperone training had not been undertaken by these staff members and they had not been Disclosure and Barring Service checked as they would never be left alone with a patient. However, all staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination

- The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were required to read as part of their induction which was accessible on all computer desktops for all staff. However, the last practice risk assessment was carried out in 2011 and we found the hot water tap in the patient's toilet was extremely hot and the emergency pull cord was too short for patients to be able to use if they had a fall in the toilet. We discussed this with the practice manager who told us they would ensure this is addressed as a matter of urgency.
- Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out in January 2015. All equipment had also been PAT tested in January 2015.
- Appropriate standards of cleanliness and hygiene were followed. There was an infection control policy and protocols in place. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training. However, we noted that the last annual infection control audit was undertaken in 2011, this had highlighted the need to remove carpets from the consulting rooms but the practice had not yet

Are services safe?

removed them. Cleaning records were kept which showed that all areas in the practice were cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Medicines were stored in medicine refrigerators in the nurse's treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The GPs and nurses shared latest guidance on medication and prescribing practice at the weekly clinical meetings, for example the prescribing of antibiotics.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For

example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service

- The practice manager Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The reception manager occasionally provided cover in reception during busy periods.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice did not have a defibrillator available on the premises and had not carried out a risk assessment. There was oxygen with adult and children's masks. There was also a first aid kit and accident book 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 fit for use.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The GPs told us they attend “hot topics” courses annually and provided feed back to the weekly clinical meeting. The practice had access to guidelines from NICE and any changes were cascaded to the GPs, nurses and registrar who used this information to develop how care and treatment was delivered to meet needs. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice manager told us they used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The latest QOF scores for 2014-2015 was 93% which was 6% above the CCG average but 1% below the England average. They had a 4.5% exception reporting.

The QOF data showed;

- Performance for diabetes related indicators was 74.4% which was 5.4% below the CCG and 10.2% below national average.
- The percentage of patients with hypertension having regular blood pressure tests was 100% which was 6.6% above the CCG average.
- The dementia diagnosis rate was 100%, which was 16% above the CCG and 5.5% above the national averages.

However, we found the practice had not completed any two clinical audits. The GPs showed us details of two clinical audits, including one for dermatology and an unplanned admission audit. The purpose or the criteria for the audits were not recorded and all of the documents we were shown were incomplete. The second phase had not been completed. There were no notes of any discussion

about the audit. There was no timeline to suggest that a second cycle of audit would be completed, neither was there any plan to disseminate learning from the audits once they were completed.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme which covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. Most staff had had an appraisal within the last 12 months.
- Staff also had to complete regular mandatory courses such as annual basic life support and health and safety training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics.
- Staff also had access to additional training to ensure they had the knowledge and skills required to carry out their roles. For example, reception staff told us they had received information governance and customer service training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice’s patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people’s needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they

Are services effective?

(for example, treatment is effective)

are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a quarterly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practice's responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. A care navigator was available at the practice one day a week. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 77%, which was above the CCG average of 72% and below the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 65% to 96% and five year olds from 57% to 94%. Flu vaccination rates for the over 65s were 60%, and at risk groups 46%. The practice was aware that these were below the CCG and national averages and had put in processes to try to improve these outcomes.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 18 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. However, some patients told us they felt rushed and not listened to by one GP at the practice and had refused to see that particular GP on occasions.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey published in July 2015 and the friends and family survey. The evidence from both these sources showed patients were generally satisfied with their experience at the practice. For example,

- 80% of patients who responded described their overall experience as good as compared to the local average of 80% and the national average of 85%.
- 78% of practice respondents saying the GP was good at listening to them as compared to the local average of 84% and the national average of 89%.
- 75% said the GP gave them enough time as compared to 81% and 87% respectively for the CCG and the national average.
- 74% said the last nurse they spoke to was good at treating them with care as compared to the local average of 83% and the national average of 85%.

- 86% patients said they found the receptionists at the practice helpful which were comparable to the CCG and national averages.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice good in this area. For example, data from the national GP patient survey showed 73% of practice respondents said the GP involved them in care decisions compared to 76% for the CCG and 81% nationally. The care plans we reviewed demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they always felt involved in decision making about the care and treatment they received from two GPs, however some patients said they did not always feel involved, on occasions with another GP. They also told us they felt listened to and supported by all other staff and were given enough information to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation 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.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and information on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carers were asked to complete a carer's forms where appropriate and there were written information available for carers to ensure they understood the various avenues of support available to them.

There was a system of support for bereaved patients both provided by the practice and other support organisations. GPs told us they would make phone calls to families who

Are services caring?

had suffered bereavement. People were given the option to be referred for bereavement counselling with the in-house counsellor or signposted to a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. Deaths of patients were discussed at the weekly practice meetings.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice attended a monthly locality meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- Patients over 75 years had a named GP to co-ordinate their care and are offered an annual health check and vaccinations such as Influenza and Pneumococcal. There was a register for older people who have complex needs, required additional support or were housebound and care plans were in place to ensure these patients and their families received coordinated care and support.
- The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses to discuss patients and their family's care and support needs. Patients in these groups had a care plan, were reviewed every six to twelve months and would be allocated longer appointment times when needed.
- The practice ran six-weekly well baby clinics which provided an opportunity for mothers to express any concerns that they may have to the GP, nurse or health visitor. GPs told us they liaise regularly with health visitor who also attend some Multi-Disciplinary Team Meetings. On the day appointments were given to all children under 5's when their parent requested the child to be seen for urgent medical matters.
- The practice offered working aged patients access to extended appointments three days a week. They also offered on-line appointments, online ordering of repeat

prescriptions, and telephone consultations to speak with the GP or nurse in relation to test results. They also provided travel clinics and immunised students that were participating in the new Meningitis ACWY programme.

- The GPs told us that patients whose circumstances may make them vulnerable such as those under safeguarding or people with learning disabilities were offered regular health checks and follow-up. They said they would also refer them to other agencies including social services, Improving Access to Psychological Therapies IAPT, Mind, and Carers Groups. Any patients who were deemed vulnerable were also brought to the weekly clinical meeting by the relevant clinician and discussed.
- The practice had a register of patients experiencing poor mental health. These patients were invited to attend annual physical health checks. They also had a primary care liaison nurse for mental health, a counsellor and CBT psychologist based at the practice one day a week. Their role was to support patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. They would also see patients referred to them from the practice. We saw they would refer patients to Improving Access to Psychological Therapies (IAPT).
- Patients with Dementia were assessed by the clinical team and we saw that they ran Dementia Awareness workshops organised in the practice in conjunction with the CCG Dementia Specialist.
- The GPs told us they were comfortable to initiate discussion about weight and would refer patients to "My Action", exercise sessions in the local gym.

The premises however were not easily accessible to patients with disabilities. There were a number of steps down to the reception and waiting area. We discussed this with the practice and were told they had applied for planning permission and funding to have a ramp constructed. They also said that GPs would carry out home visits to patients who used wheel chairs. Some treatment and consultation rooms were on the first and second floors, which were accessible via a lift. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

Are services responsive to people's needs?

(for example, to feedback?)

The practice was open from 8.30am to 6.00pm Mondays, 8.30am to 7.40pm Tuesdays, 8.30am to 1pm on Wednesday, 8.30am to 8.30pm on Thursdays and 8.30am to 5pm on Friday, which was particularly useful to patients with work commitments. The telephones were answered throughout the opening hours and a recorded message was available at all other times. Appointment slots were available throughout the opening hours, except between 1pm and 2pm daily, when the practice was closed for lunch although patients could attend specialist services or see the nurse during the lunch hour. Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

Feedback from the national GP survey published in 2015 was relatively positive about the appointment system. For example;

- 74% of respondents described their experience of making an appointment as good and
- 73% were satisfied with the surgery's opening hours.

Feedback from patients was mixed about the appointments. Some stated they could always get an appointment when needed although they said it was sometimes difficult to get through to the surgery on the

phone. The practice manager told us they were aware of these concerns and was trying to address them. However, 87% of the respondents to the GP survey said they were able to get an appointment the last time they tried.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found these were dealt with in a timely way in line with the complaints policy and there were no themes emerging. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, we saw that where a patient had complained about missing test results, a review was carried out and a new procedure implemented.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice did not have a clear strategy or supporting business plans which reflected the vision and values. The lead GP told us their vision was to deliver a high quality patient care, however this was not documented in the form of a mission statement or displayed anywhere. Staff we spoke felt the vision was to deliver good care, but said that vision and values were not discussed.

Governance arrangements

There was a documented leadership structure and staff felt supported by management. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. We found:

- The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at five policies and procedures and found that the Health and Safety policies and procedures had not been reviewed since 2012, all others were up to date.
- The practice held weekly governance meetings which were attended by the partners and the practice manager. They said they discussed finance, staff issues and premises. However, we were told no notes were taken of these meetings.
- The practice had an understanding of their performance. They attended a monthly peer review meeting with other practices and used the Quality and Outcomes Framework (QOF) to measure their performance, which showed it was performing in line with national standards. Staff told us QOF data was regularly reviewed and discussed at the practices monthly meetings.
- The practice did not have a programme of continuous clinical audit and no audits had been completed in the last 12 months. They showed us two clinical audits that

had been started in the last year; however these were not completed audits. There was no evidence of the practice having improved patient outcomes through monitoring the quality of the service they provided.

- The practice did not have robust arrangements in place for identifying, recording and managing risks. They did not have a risk register for

Leadership, openness and transparency

The lead GP prioritised safe, high quality and compassionate care and was visible in the practice. Staff told us that they were approachable, always took the time to listen to all members of staff and encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held and that there was an open culture within the practice. They said they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the practice manager. All staff were involved in discussions about how to run and develop the practice and were encouraged to identify opportunities to improve the service delivered by the practice

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through patient surveys, friends and family test and complaints received. We looked at the results of the on-line patient survey from 2014 and saw that one area of concern was access to the building which the practice manager told us they had already been addressing. The practice was in the process of setting up a patient participation group (PPG) and had five patients expressed an interest to join. However, the practice manager told us they were trying to increase numbers and ensure they were representative of the practice population.

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

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 Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The provider did not have systems and processes in place to assess, monitor and improve the quality and safety of the services provided or to monitor and mitigate the risks. There was no two cycle clinical audit completed in the last five years to evaluate and improve outcomes for service users. The practice had not completed an environmental risk assessment in the last two years to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The hot water tap in the patient's toilet was extremely hot. Regulation 17 (1)(a)(b)
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The practice did not have processes in place to prevent the spread of, infections, including those that are health care associated. They had not completed a recent infection control audit. The last infection control audit was undertaken in 2011, this had highlighted the need to remove carpets from the consulting rooms but the practice had not yet removed them. Regulation (1)(2)(h)