# Connaught Surgery

## Quality Report

144 Hedge Lane
Palmers Green
London
N13 5ST
Tel: 0208 920 9606
Website: www.connaughtsurgery.co.uk

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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.

# Summary of findings

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# Summary of findings

## Overall summary

Connaught Surgery is located in Palmers Green, North London. The practice served a diverse population with low deprivation and a high proportion of elderly patients. The practice delivered primary medical services to approximately 4,400 patients and is registered to provide the following regulated activities which we inspected: diagnostic and screening procedures, family planning, surgical procedures and treatment of disease and disorder or injury and serves. It is operated by two GP partners (one female, one male), a Practice Nurse, a Practice Manager and a team of reception and administration staff. The practice also supported year 4 & 5 medical students from a London medical school.

We saw that the service provided was safe, effective, responsive, caring and well-led, but there were some shortfalls. All of the patients that we spoke to and those who completed comment cards said the service they received at Connaught Surgery was either good, very good or excellent. Patients spoke fondly of all the staff at Connaught Surgery. Despite the fact the practice had seen an increase in its patient list size of 25% over the last three years, patients said they were able to access both face to face and telephone appointments relatively easily. The practice offered an extended hours service and patients valued this arrangement. We saw that staff responded to urgent appointment requests wherever possible. Out of hours, patients could access care through the national 111 emergency service.

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The service understood the needs of its patient population and were increasingly improving patient outcomes including those for older people, people with long term conditions, mothers, babies, children and young people, the working age populations and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

We found specific care pathways in place for patients with long term conditions such as diabetes or high blood pressure. Patients care management included referral to other healthcare professionals in both primary and secondary care in a timely way. We found that patients received safe care and they were protected from abuse because staff received appropriate training and the practice had systems in place for safeguarding of vulnerable adults and children. The practice had effective systems in place and patients were protected from the risks associated with infection prevention and control and medicines were safely managed. Some areas of the premises required repair and redecoration including the reception area, the public toilet and the mother and baby reception area. There were effective relationships with district nurses, care homes and local pharmacies.

We did note some areas which required improvement and we have told the practice to take action on these matters. Staff had not received training in the requirements of the Mental Capacity Act (2005) Clinical staff did not demonstrate knowledge of the requirements for consent to treatment, in keeping with best-practice and this had the potential to impact on patients who lacked capacity. The practice had a number of mechanisms in place to report and record safety.

# 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 met all the standards.

There was a shared awareness of risk by all staff and information was considered from a range of sources including complaints, significant events and clinical audits. Mechanisms were in place to report, record and analyse safety, incidents, serious events and allegations of abuse.

The practice had effective systems in place to safeguard vulnerable patients from the risk of abuse. Safeguarding policies were in place for both vulnerable adults and children . Staff had received training in safeguarding vulnerable adults and children and they were able to describe the signs of possible abuse and knew what to do if they had concerns about patients.

Patients were protected from the risks associated with the recording, handling, administration and disposal of medicines.

Emergency equipment and drugs were available and these were easily accessible to staff. We saw evidence of openness and transparency when things went wrong, for example medication errors.

There were policies and procedures and effective systems in place to reduce the risk and spread of infection.

**Are services effective?**

The practice did not meet all the standards. This is being followed up and we will report on any action when it is complete.

All staff had opportunities to develop their skills and knowledge, including where appropriate, maintaining continuing professional development. However, staff were not trained in the requirements of the Mental Capacity Act 2005 (MCA) and as a result they were not confidently able to describe how they would assess patients capacity to consent to treatment. This had the potential to impact on patients who lacked capacity.

Clinicians were able to respond to patients changing needs and patients needs were prioritised according to risk. Care and treatment, for example prescribing, was delivered in-line with recognised standards and guidelines.

# Summary of findings

Care was personalised and holistic taking account of the whole-person and responding to a range of physical, psychological and social needs. The practices' own data indicated that care plans were in place for most patients with complex needs, including those with poor mental health.

We found that the practice positively and proactively engaged and worked in partnership with other services to meet patients diverse needs. For example, we saw timely follow-up of patients with end-of-life care needs and there were effective care pathways for patients with diabetes and other long term conditions.

There was a fortnightly multi-disciplinary team (MDT) teleconference where patient care was discussed. However, the practice might like to note that some engagement with other professionals was not routinely scheduled, but relied on the flexibility and good will of the GPs. This was described as an open-door policy. To-date these arrangements had been adequate and all stakeholders that we spoke to said the practice was highly effective and responsive.

**Are services caring?**

The practice met all the standards.

All of the patients we spoke to and those who completed comment cards before our inspection described the service provided as either good, very good or excellent. Patients spoke very highly about the extent to which they were treated with dignity and respect by all staff at the practice. They commended clinicians on their flexibility and compassionate approach.

Patients said they were fully involved in decisions about their care and treatment. They said they were given sufficient time to discuss their concerns during appointments and as a result they felt listened to and valued. Staff told us that where patients were known to have particular needs, for example if they were recently bereaved or identified as vulnerable, they were booked a double-appointment slot.

Most patients that we spoke to said they would recommend the practice to friends and family and some said they had actually done so.

**Are services responsive to people's needs?**

The practice met all the standards.

The practice building was wheelchair accessible. Interpreting and translation services were available, but staff said that these were not always as readily available as they would wish.

# Summary of findings

Patients told us that access to routine and emergency appointments was good. This was despite the fact that the practice had taken on a significant number of additional patients following the closure of another local practice.

The practice had in place effective systems and processes for the management of complaints, comments and compliments.

**Are services well-led?**

The practice met all the standards.

There was evidence of on-going, separate processes whereby staff monitored and reviewed feedback from patients who used the service, incidents, complaints and the outcome of audits to drive service improvement.

Governance arrangements were clear and relevant policies and procedures, including a statement of purpose, set out who was responsible for what. A well organised and focussed practice manager contributed significantly to the leadership of the practice.

All staff understood and were able to articulate their roles. Staff told us they received good levels of support from each other and we observed a strong culture of collaboration and team-work to achieve shared goals. During the inspection it was clear that staff had mutual respect for one-another. Separate clinical and non-clinical team meetings took place. Staff had introduced social gatherings amongst themselves to further strengthen team work.

We saw that all staff received annual appraisals and doctors were able to tell us their individual annual appraisal and revalidation time-frames. Supervision and support arrangements were in place clinical supervision for the practice nurse.

# 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 was responsive to the needs of older people. Patients who completed our comment cards were very complimentary about the quality of care and treatment they received. The surgery was wheelchair accessible and the public toilet had a hand-rail to support patients with mobility problems.

Staff had not received training in the Mental Capacity Act 2005 (MCA).

Many of the patient participation group members (PPG) were older patients and patients said they felt their views had been listened to and action had been taken to improve the service as a result of what they fed-back. Clinical staff had received training so they could better respond to older patients needs, for example in elderly care or communication with patients experiencing hearing and sight-loss.

### People with long-term conditions

The practice manager used a tool to identify and highlight people with long-term conditions held on a register. This meant that patient's care was regularly monitored and reviewed and patients were invited into the practice for regular check-ups.

The practice was responsive to the needs of people with long-term conditions. Staff held registers for people with long-term conditions such as those with diabetes, heart conditions, dementia, stroke, palliative care and hypertension.

### Mothers, babies, children and young people

The practice was responsive to mothers, babies and young people. The practice had a second reception area dedicated to expectant or new mothers. This meant that mothers could, for example, breast-feed their baby, weigh or change the baby in privacy.

All staff had received training in safeguarding children and had a good awareness of the signs of possible abuse.

### The working-age population and those recently retired

The GP practice provided a safe, effective, caring, responsive and well-led service for people of working-age and those recently retired. The practice offered appointments early in the morning and late evening to suit patients who were of working age or those who were recently retired and wanted the flexibility. A doctor offered telephone triage and where necessary re-directed patients to

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| appropriate appointments. Through regular review of staffing levels and use of a regular locum doctor, the practice manager worked alongside reception staff, to ensure that sufficient numbers of appointments were made available on a daily-basis. | |
| **People in vulnerable circumstances who may have poor access to primary care**<br>The practice was responsive to the needs of people in vulnerable circumstances who may have poor access to primary care. Where they were aware of people in vulnerable circumstances they said they were flexible in their approach, for example registering patients irrespective of whether they had a permanent residential address or not. The practice had more to do to identify people in vulnerable circumstances. | |
| **People experiencing poor mental health**<br>The practice was responsive to the needs of people experiencing poor mental health. The practice engaged with patients experiencing poor mental health to ensure that regular physical health checks were carried out. This meant the patients care, treatment and medication could be monitored and reviewed. | |

# Summary of findings

## What people who use the service say

During our inspection we spoke with a total of 20 patients who used the practice (including 10 members of the patient participation group) and we received and reviewed 58 comments cards.

All of the patients we spoke with and those who completed comment cards before our inspection, described the service provided as either good, very good or excellent. Patients spoke very highly about the extent to which they were treated with dignity and respect by all staff at the practice. Some said that the practice was more like a family environment. Most patients that we spoke to had been registered at the practice for many years. Patients commended clinicians and non- clinicians alike for their willingness to help, flexibility and compassionate approach.

Patients said they were fully involved in decisions about their care and treatment. They said they were given sufficient time to discuss their concerns during appointments and as a result they felt listened to and valued. Patients told us that if they experienced particular difficulties, for example, if they were experiencing bereavement or in need of psychological support, they were offered a double-appointment slot. Most patients said they would recommend the practice to friends and family and some said they had done so. There was a patient participation group (PPG). The PPG was very positive about the extent to which their views were listened to and they sited examples of their impact and action the practice had taken as a result of the groups feedback.

## Areas for improvement

**Action the service MUST take to improve**

- Staff had not received training in the requirements of the Mental Capacity Act 2005 (MCA). As a result clinical staff were not confidently able to describe how they would assess people's capacity to consent to treatment. This had the potential to impact on patients who lacked capacity as their capacity may not be assessed using best practice guidance.

**Action the service COULD take to improve**

- Interpreting and translation services were available, but staff said that these were not always as accessible as they would wish. Staff had to book translation services well in-advance and Language-Line telephone interpreting service was not available locally.
- Patients were not yet able to book appointments on-line.
- Some areas of the premises required repair and redecoration including the reception area, the public toilet and the mother and baby reception area.

# Connaught SurgeryConnaught Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection was led by a CQC Lead Inspector. A GP and an expert by experience were also part of the inspection team.

## Background to Connaught Surgery

Connaught Surgery is located in Palmers Green, North London. The service was provided to a diverse population with relatively low deprivation and a high proportion of elderly patients. The practice is registered to provide the following regulated activities which we inspected: diagnostic and screening procedures, family planning, surgical procedures and treatment of disease and disorder or injury and serves approximately 4,400 patients. It is operated by two GP partners (one female, one male), a Practice Nurse, a Practice Manager and a team of reception and administration staff. The practice also supported year 4 & 5 medical students from a leading London medical school.

There were effective joint-working relationships with district nurses, care homes and local pharmacies.

## Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward.

## 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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

We carried out an announced inspection on 3 & 4 June 2014. The inspection took place over two days and was led by an inspector, a GP and an expert by experience were also part of the inspection team. Before our inspection we

# Detailed findings

spoke with 6 people who were registered with the practice and staff from a care home for people with learning disabilities and poor mental health. We also spoke to a local pharmacist and a palliative care team, who worked jointly with the practice. (Palliative care teams support people who need end-of-life care and support).

# Are services safe?

## Summary of findings

The practice met all the standards.

There were mechanisms in place to report and record safety, incidents, serious events analysis and allegations of abuse. The practice had effective systems in place to safeguard vulnerable patients from the risk of abuse.

Safeguarding policies were in place for both vulnerable adults and children. Staff were able to describe the signs of possible abuse and they knew what to do if they had concerns about patients.

Patients were protected from the risks associated with medicines and the systems in place to store and monitor medication were adequate.

There was a shared awareness of risk by all staff and separate information was considered from a range of sources including complaints, significant events and clinical audits. However, there was scope for improvement.

We saw evidence of openness and transparency when things went wrong, for example medication errors.

There were effective systems in place to reduce the risk and spread of infection.

## Our findings

### Safe patient care

The practice used a range of different information sources including safeguarding activity, complaints, incidents, audits and feedback from patients using the service to shape and inform its approach to delivering safe patient care.

Patients that we spoke with said they had confidence in clinical staff to deliver safe patient care. Staff showed us how they carried out checks on the suitability of locum GPs, for example through the General Medical Council (GMC) register of practicing doctors and recruitment checks included references and professional liability insurance.

Locum GPs were given their own individual log-in details for using the computer system. This ensured there was an audit trail which showed which staff had accessed patient records, prescriptions and other correspondence.

The practice was able to provide an example where staff had intensified patient follow-up to maintain safe patient care. One example, included a patient who had hypertension. Clinical staff described how they attempted to actively engage the patient. Where they had opportunities to do so, they monitored the patients condition for some months. The GPs explained the risks of this health condition and the risks of not taking the prescribed medication to the patient. The patient disengaged and presented two years later with malignant hypertension (very high blood pressure). GPs said they spent a great deal of time with the patient, again trying where possible to re-educate them about their condition and treatment plan, with a view to preventing further deterioration in health and encouraging patient self-care.

Dedicated members of the administration team were responsible for summarising patients paper medical records and transferring these onto the electronic computer system when patients registered at the practice.

The practice manager supervised this activity to assure quality.

### Learning from incidents

The practice had in place a process which encouraged learning from incidents.

Staff told us about a number of incidents which had required them to review, amend and strengthen clinical

practice. One example given involved a locum GP prescribing Penicillin for a patient who was allergic to it. The patients allergy was clearly identified in their individual records. The patient themselves highlighted the error and notified the practice prior to taking the medication. As a result of this incident management took action to prevent any recurrence. We saw written evidence that a significant event analysis was carried out and relevant processes and systems including induction for locum staff was strengthened. Staff said they discussed significant events within practice meetings to share and disseminate learning although this was not always recorded in minutes of meetings.

### Safeguarding

Staff had a good level of awareness of both safeguarding vulnerable adults and children. Staff were able to describe some of the potential signs of abuse and they understood the important role they played as individuals in wider local safeguarding arrangements. The practice had up-to-date policies and procedures for both adults and children's safeguarding and these were fit-for-purpose. The lead clinician was the nominated lead for safeguarding adults. All staff had received relevant basic safeguarding adults training. The lead clinician was the nominated lead for safeguarding children. All non-clinical staff had received relevant basic safeguarding children training. Both GPs were trained to Level 3 in safeguarding children.

The practice had a system to identify vulnerable patients on their computerised patient records system. This information was highlighted on patient records when they contacted the practice or attended any appointments so that staff were aware of any issues.

### Monitoring safety and responding to risk

A detailed business continuity plan was in place to ensure the service could be provided in the case of an emergency to ensure patients and staff safety. The practice manager had lead responsibility for keeping this up-to-date. The plan was fit-for-purpose and took account of foreseeable emergencies. We saw evidence that the practice had systems in place to ensure sufficient numbers of staff were available and this was reviewed and monitored effectively. The practice manager provided oversight of the staffing establishment.

An audit had been carried out to review staffing levels. As a result of this six month audit, changes were made to the timing of some clinics and staffing levels were altered accordingly. For example, the gynaecology clinic was moved from the afternoon to a morning slot. This was as a result of mothers saying the afternoon clinic was inconvenient because it impacted on them being able to collect children from school.

The practice manager carried out annual risk assessments of the building including fire safety audits and health and safety assessments. All staff had received training in health and safety. Staff said they had regular fire drills. A fire alarm was serviced annually by an external contractor and the practice had up to date safety certificates for gas and electricity.

### Medicines management

There were appropriate arrangements for the obtaining, recording, handling, storage and disposal of medicines. We looked at how the practice stored and monitored medication, to ensure patients received medicines that were in date and correct. This included emergency medicines and vaccines. Staff told us they did not hold any controlled drugs.

We looked at the two vaccine fridges and they were locked. We saw that refrigerator temperatures, which were in-range on the day of the inspection, were monitored daily and logged. The practice nurse supported by both GPs ordered the vaccines and they had a system to check and identify out of date vaccines.

We reviewed the doctors home-visit bag and emergency medicine held at the surgery. Both contained commonly used emergency medicines. There was an oxygen cylinder

which was in working order and checked on a regular basis, with all the relevant connecting tubes and face masks present. All the medication found in the doctor's bag and the emergency medicines were well within date.

### Cleanliness and infection control

The practice had an infection control and prevention policy and the practice nurse was the clinical lead infection control. We found that the premises were visibly clean and tidy in all areas.

A cleaning contract was in place and we were told this was for nine hours a week. However, staff said that the nurse and reception staff had responsibility to carry out specific cleaning duties using a cleaning schedule. The practice manager showed us that different coloured mops/ mop-buckets were used for different areas of the building.

# Are services safe?

The consultation rooms that we checked had newly fitted sinks and easy-clean flooring. Hand gel, soap and paper towels were available at all sinks and there were wall mounted reminders about hand-washing. Disposable privacy curtains were used and there was a system to ensure they were regularly changed.

A contract was in place to remove clinical or hazardous waste on a regular basis and external storage bins that we saw were safe and secure. A clear colour coded system for the safe disposal of general, clinical and hazardous waste was in place and the practice's infection control policy contained written guidance for staff reference.

The practice manager had a written plan in place to carry out the remaining minor improvements to the premises. These included changing the remaining metal blinds in consultation room 2 and the cold water piping in the patients toilet was slightly exposed and needed boxing-in.

Staff said the building was in need of significant investment. We were told about discussions for the practice to merge with a neighbouring practice, but the detail including precise time-scales to take forward these talks were not yet clear.

### Staffing and recruitment

The practice had a recruitment policy which set out the process for recruiting clinical and non-clinical staff. We saw that relevant pre-employment recruitment checks were carried out before all staff started employment. The practice manager said that references had been obtained for all staff l. We noted that a reference for a locum doctor had not been directly followed up with referees to verify it.

The practice manager said they had enquired about the locums suitability with other previous employers, but the practice might like to consider verifying references directly with referees in the future.

All staff had criminal records checks to confirm their suitability prior to starting employment.

### Dealing with Emergencies

We saw there were appropriate and sufficient emergency medicines available at the practice.

The surgery did not have a cardiac defibrillator device (a defibrillator is an electrical device that provides a shock to the heart when there is a life threatening erratic beating of the heart). Although not mandatory, this equipment was recommended by the Resuscitation Council (UK).

A protocol was in place to ensure that patients with infectious conditions, for example, chickenpox were asked to wait in a separate reception/ or other area. Staff told us about their written plan which set out what they would do in the case of an emergency outbreak of swine flu for example. This included alerting staff, using technology to cascade information to the public and minimising patient contact where feasible.

### Equipment

The surgery had a range of medical equipment in use. Systems and processes were in place to service and monitor equipment. There was one oxygen cylinder and an emergency trolley for use in a medical emergency. A nebuliser was available for children and adults, breathing masks and goggles for use in emergencies, spirometer, ear syringe machine and a weighing/height machine. Arrangements for ensuring that only in-date equipment was used were effective.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

The practice did not meet all the standards. This is being followed up and we will report on any action when it is complete.

Staff had not received training in the requirements of the Mental Capacity Act 2005 (MCA). As a result of not receiving relevant training clinical staff were not able to describe how they would assess patient capacity to consent to treatment. This had the potential to impact on patients who lacked capacity.

Clinicians were able to respond to patients changing needs and their needs were prioritised according to risk. Care and treatment, for example prescribing, was delivered in-line with recognised standards and guidelines.

Care was personalised and holistic taking account of the whole-person and responding to a range of physical, psychological and social needs. The practices' own data indicated that care plans were in place for most patients with complex needs, including those with poor mental health.

All staff had opportunities to develop their skills and knowledge, including where appropriate, maintaining continuing professional development.

There was a fortnightly multi-disciplinary team (MDT) teleconference where patient care was discussed. Most engagement the practice had with other professionals, about patient care, was not routinely scheduled, but relied on the flexibility and good will of the GPs. This was described as an open-door policy. We noted that to-date these arrangements had been adequate and all stakeholders that we spoke to said the practice was highly effective and responsive.

## Our findings

**Promoting best practice**

We spoke with two GP's and a practice nurse about how they received updates relating to best practice or safety alerts. The practice manager ensured any alerts or best practice updates were disseminated to clinical staff through the email system. The nurse said that senior clinicians were always available for support and guidance if required. Where alerts identified the discontinuation in use of a particular medication, for example, the practice manager explained how senior clinicians worked jointly with them to identify affected patients and to go through patient notes to develop and update individual care plans.

As an additional safeguard, the practice manager ensured that all clinicians signed a register to confirm they had received and read relevant alerts.

The practice did not have a policy which set-out the requirements of the Mental Capacity Act (2005). Staff had not received training in the requirements of the Act and as a result staff awareness was vague. Staff were not confidently able to tell us how they would go about assessing patients capacity to consent. Patients who used the service were not effectively protected by consent safeguards.

Registers were maintained for patients with long-term conditions such as those with diabetes, heart conditions, dementia, stroke, palliative care and hypertension. The practice manager used a tool to identify and highlight patients with long-term conditions on the registers. This meant that patients care could be regularly monitored and reviewed and patients were invited in for check-ups with the practice nurse who was suitable qualified to carry out such checks. Examples included patients with diabetes being invited in to the foot-clinic. Hypertensive patients were invited in for regular blood pressure checks.

The practice was ensuring that all smokers over the age of 40 years old were assessed for chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases. Additionally, the practice reported that they had referred 22 patients to a local smoking cessation clinic, Inner Vision, between April 2013-March 2014.

# Are services effective?

## (for example, treatment is effective)

### Management, monitoring and improving outcomes for people

The CQC data pack which contained a range of information we hold about the service, identified that the practice had relatively low numbers of patients referred for smoking cessation. The numbers of patients with severe mental illness who had received a physical health-check were low and the extent to which the practice was offering follow-ups for patients with asthma was low. However, the practice's own locally held data indicated better performance and outcomes for patients than the intelligence data obtained before our inspection. We discussed the data we had obtained before our inspection with the practice and they said they had experienced some coding problems which may account for some variation in the data. We were not able to corroborate whether in fact any coding errors had occurred or not. We saw that the practice manager had a good grasp of the clinical review system and this was helping clinicians to improve the service and increasingly this was providing improved outcomes for patients.

The practice had an on-going programme of clinical audit to shape and inform improved outcomes for patients. Staff showed us evidence of a number of different audits with evidence of how these were making a difference to patients. Some of these included, calcium & vitamin D therapy, appointments and repeat prescribing audits.

Quality Outcomes Framework (QOF) indicators showed the practice met 100% of all targets for follow-up reviews concerning patients with asthma, heart failure, chronic heart disease, hypertension and mental health review care plans. QOF is the annual reward and incentive programme detailing GP practice achievement results. The practice said they used the QOF scores to monitor and drive improved patient outcomes.

### Staffing

The practice had in place a detailed induction programme for all staff whether permanent or on a short term basis. The practice manager had responsibility for ensuring that staff received safe induction. All staff received annual appraisals and doctors were able to tell us their individual annual appraisal and revalidation time-frames. Supervision and support arrangements were clear including clinical supervision for the practice nurse which was provided by the GPs.

All staff received time to support their learning and development. Clinical staff were able to maintain their individual continuing professional development requirements. Training records indicated that all staff had completed training relevant for their role, and that this was regularly updated. Examples of training completed included, basic life support, infection control, health and safety, safeguarding and information governance. Staff meetings were held on a weekly basis although these were separate for clinical and non-clinical staff. The practice manager attended both meetings and had an over-view of all practice matters. All staff that we spoke to said they found the training, team meeting and support arrangements, including the way information was shared, very effective.

Connaught Surgery was a training practice and supported Year 4 & 5 medical students. The practice received 3 students each year and both GPs supervised students. This helped to ensure the practice kept abreast of the latest developments and added value to the practice overall, including patient outcomes.

### Working with other services

Healthcare partners said that the practice worked well with others and always responded in a timely way to meet patients needs. The practice was described as having an "open-door policy" which meant that partners felt able to drop into the surgery at any time, to discuss matters about patient care and partners said that this flexible arrangement worked well for all concerned.

Staff said there were effective arrangements in place to support end-of-life care. Palliative care team representatives said there were effective joint working arrangements with the practice and they identified the practice as being particularly proactive and responsive to patients individual needs. We heard that, on occasions, GPs at Connaught practice came into work on their day-off to ensure that patients changing needs were effectively met. Staff at the practice were said to be patient centred, caring and considerate.

The practice contributed to a fortnightly multi-disciplinary team (MDT) teleconference. We were told that this had contributions from professionals including mental health, district nurse, community matron and social work staff. The practice demonstrated how they used a risk stratification tool to identify patients who had low, medium and high risk

# Are services effective?

## (for example, treatment is effective)

needs based on profiles such as clinical presentation, history of hospital admission and cost of care. Clinicians said this helped them to prioritise patients for clinical MDT discussion through the fortnightly teleconference.

To ensure continuity of care there was daily communication with the local out of hours service and staff explained that this took place through correspondence four times a day. The practice was currently undertaking an audit to identify patients who frequently used out of hours including accident and emergency (A&E). We were told how staff were using public information and one to one conversations with patients to re-educate patients, so they could make better care and support choices out of hours .

### Health, promotion and prevention

The practice nurse had a key role in driving the health promotion and prevention agenda. There was a large range of health promotion information leaflets available at the practice. This included information on safeguarding vulnerable adults and children, carers support and requesting a chaperone. The Life Channel (a TV channel) was used in both reception areas and this promoted information about diabetes care and other health promotional information. An LED appointment check-in system, also provided healthy living and lifestyle information drawn from local, regional and national evidence.

Clinicians showed us how they were using a patient health questionnaire to identify the early signs of depression. Clinicians said they found this a helpful tool as increasing numbers of patients presented with depression and anxiety. Staff told us they had referred patients to Increasing Access to Psychological Therapies (IAPT) support, but that patients had experienced lengthy waits, sometimes of up to three months. Clinicians said that in these circumstances they had sometimes asked patients to visit them on a weekly basis to ensure patients received emotional support and were well monitored, until the IAPT commenced.

We were told how NHS physical health checks for patients aged over 40 years old was helping to identify patients at risk of diabetes. Staff had an awareness of the needs of carers and staff said they routinely referred patients to the local carers association.

The practice performance on treatment of patients registered and diagnosed with atrial fibrillation and prescribed anti-coagulation therapy was good. The practice showed us their own locally owned data which indicated the 70% target had been achieved.

# Are services caring?

## Summary of findings

The practice met all the standards.

The patients we spoke with and those who completed comment cards before our inspection described the service provided as either good, very good or excellent.

Patients spoke very highly about the extent to which they were treated with dignity and respect by all staff at the practice. They commended clinicians on their flexibility and compassionate approach.

Patients said they were fully involved in decisions about their care and treatment. They said they were given sufficient time to discuss their concerns during appointments and as a result they felt listened to and valued. Staff told us that where patients were known to have particular needs, for example if they were recently bereaved or identified as vulnerable, they were booked a double-appointment slot.

People that we spoke to said they would recommend the practice to friends and family and some said they had actually done so.

## Our findings

**Respect, dignity, compassion and empathy**

Without exception, all patients whose comments we considered said that the care and treatment they received from the practice was either good, very good or excellent.

Patients we spoke with said they were treated with a high-degree of dignity and compassion by all staff clinical and non-clinical. Many of the patients who responded using our comment cards highlighted the kindness and courtesy of staff. Many commented that both GPs were patient and caring. Other comments praised the professionalism and helpfulness of the practice nurse and receptionists.

During the inspection one person who used the service commented that both GPs were particularly good at dealing with patients who had poor mental health. Doctors that we spoke to showed a genuine interest in mental health and they recognised this as a growing social concern for their patients.

Staff told us that from time-to-time, patients were given news at the hospital that was difficult and distressing for them, for example, the diagnosis of a significant or terminal condition. On these occasions, staff said, when alerted by the patient, they sometimes invited them to come into the surgery to have a chat and a cup of tea with one of the clinical staff. Staff said that some patients who used services had welcomed this offer.

We saw there was a full range of health related leaflets in the patient waiting area. Although the practice had no specific expertise in bereavement support, they were able to signpost patients experiencing bereavement to a nearby day centre which dealt with patients at end-of-life and their families. On the day of the inspection, two patients were seen to be greeted in a caring, considerate and professional manner by staff.

Staff said that in circumstances where patients had experienced a recent bereavement they routinely sent the family a sympathy card. When appropriate, patients experiencing bereavement were referred for bereavement counselling and although the practice did not have any specialist skills in this area, staff said they had provided emotional support to many families.

# Are services caring?

### Involvement in decisions and consent

Patients that we spoke with said they felt very involved in decisions about their care. Most were satisfied that they were able to obtain an appointment within a reasonable time. All those interviewed, praised the practice for seeing patients needing an emergency appointment quickly. A number of patients said they appreciated the practice tradition of providing telephone triage, which was carried out by one of the GPs, if an on-the-day appointment was not available.

An area which did require improvement was in terms of capacity to consent to treatment under the Mental Capacity Act 2005 (MCA). We talked with clinical staff about this area of work. Staff were not trained in the requirements of the MCA 2005 and as a result they were not able to describe how they would assess patients capacity to consent to treatment, using best practice guidance. This had the potential to impact on patients who lacked capacity.

The practice had conducted a patient survey during 2013-14 to involve patients in decisions. The survey was based on concerns which patients had raised through the Patient Participation Group (PPG). The key area of concern raised by the PPG was the availability of appointments, so questions focussed on this issue. The survey also included questions about access to appointments with individual clinicians and patient awareness about the range of services that were available. From the survey, most patients (80%) said they were able to get an appointment when they need it. Patients also said that they did have to wait longer, if they wanted to see a specific GP. As a result of patient feedback the practice had taken action to offer more appointments by having an additional GP available during the week and telephone triaging had also been introduced, ensuring appointments were only given if necessary. The practice had a commitment to on-going engagement of patients, so they could have continual involvement in decisions about how the practice was run.

A chaperone policy was in place to support and safeguard both patient and clinicians during medical examinations. We saw written information in the reception areas informing patients they could request a chaperone if they wanted to, increasing their choice and involvement. Staff said they had received training in acting as a chaperone although we were not able to corroborate this from documentary sources.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

The practice met all the standards.

The practice building was wheelchair accessible. Interpreting and translation services were available, but staff said that these were not always as readily available as they would wish.

Patients told us that access to routine and emergency appointments was good. This was despite the fact that the practice had taken on a significant number of additional patients following the closure of another local practice.

The practice had in place effective systems and processes for the management of complaints, comments and compliments.

## Our findings

### Responding to and meeting people's needs

The practice had a good understanding of the needs of the local population and used a number of different registers on its database and intelligence held by the clinical commissioning group (CCG), to identify local needs. There was evidence that such data was helping the practice to become increasingly effective in terms of the monitoring, follow-up and treatment of patients.

The practice responded to and met patients needs and we heard about examples of staff at the practice, going above and beyond to ensure that patients received care and treatment when they needed it. The practice told us they were in discussions with Age UK to develop a service aimed at preventing hospital admission, promoting physiotherapy, exercise and health promotion and prevention. Staff said the service would place an emphasis on early intervention and reducing patients need for longer term care and treatment. It was hoped that these plans would be finalised over the next few months.

The practice did not have a loop system, portable or otherwise to support patients with hearing loss. However, staff said patients were taken to a separate area if they had difficulties hearing reception staff, to ensure their dignity was maintained in a private setting. Staff said they routinely signposted patients who used the service, in particular elderly patients, to one of a number of the local culturally specific day centres in Enfield. These included a day centre that supported patients from Asian, Turkish and African-Caribbean communities. We heard that staff including receptionists spoke a range of languages including Gujarati, Hindi and Greek. Interpreting and translation services were available, but staff said that these were not always as readily accessible as they would wish and on occasions patients needing the service experienced lengthy waits. Language-Line was not available locally.

The premises of Connaught Surgery were wheelchair accessible and there was an accessible patient toilet.

### Access to the service

In response to increased demand for appointments to see the GPs, the practice had audited the appointments system and they subsequently appointed a locum GP one day a week. Staff said that this had created more appointments capacity although availability of appointments was an

# Are services responsive to people's needs?

## (for example, to feedback?)

on-going challenge for the practice. When we spoke to patients who used the service, they said they were usually able to obtain an appointment when they needed it. None of the patients that we spoke to or those who completed comment cards, said they experienced significant difficulties trying to obtain an appointment when they needed it.

One GP carried out triage four mornings a week between 8-9am enabling patients to see a GP, receive a telephone consultation or signposting to alternative health provision.

Patients who used the service told us they valued this. On the day of the inspection, we observed at least one person who presented at the surgery for an urgent appointment and they were seen by the triage doctor.

Staff said they prioritised appointments for patients with complex learning disabilities, for example the small number who had autism. This meant that patients saw the GP on arrival at the practice, wherever possible, and they didn't have to wait in the reception area which could get busy and unsettling for them.

### Concerns and complaints

There was information on the practice website, in the reception area and in the practice leaflet about how to raise a complaint or concern about the service. The practice had a complaints policy. They had received six complaints within the past six month period.

Records that we looked at demonstrated that complaints were logged and responded to in a timely way. Written responses were sufficiently detailed and considerate and where appropriate patients were invited in to discuss their concerns. Staff said that this approach had proven to be a constructive way of resolving disagreements. Written responses made it clear to patients that if they remained dissatisfied with the response, they had the right to take their complaint to the Health Service Ombudsman.

We saw written notices in public waiting rooms about how to make a complaint. Patients who used the service that we spoke with, told us they would raise concerns they had to reception or the practice manager. Patients said they trusted the complaints process and they did not fear making complaints because staff were open to listen. Staff told us they tried to respond to and address any concerns or adverse comments immediately including those on the practice or NHS Choices website. They said they gave patients who wished to make a complaint a copy of the procedure if the matter could not be resolved at the time.

We saw evidence of changes that had taken place as a result of patient feedback through the patient participation group, for example the appointment system and a triage system which meant that patients could obtain a consultation over the telephone. An increasing amount of information was now available on the practice website, as a result of Patient Participation Group (PPG) saying that patients did not always read posters in the waiting room.

# Are services well-led?

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

## Summary of findings

The practice met all the standards.

Governance arrangements were clear and relevant policies and procedures, including a statement of purpose, set out who was responsible for what. A well organised and focussed practice manager contributed significantly to the leadership of the practice. Clinical leadership was carried out by the lead GP. All staff understood and were able to articulate their roles.

Staff told us they received good levels of support from each other and we observed a strong culture of collaboration and team-work to achieve shared goals.

During the inspection it was clear that staff had mutual respect for one-another. Separate clinical and non-clinical team meetings took place.

There was evidence of an on-going process whereby staff monitored and reviewed feedback from patients who used the service, incidents, complaints and the outcome of audits to drive service improvement. These weren't yet pulled together to form a whole-system picture of safety, identifying themes and ensuring consistency of outcomes for patients in comparable population groups.

We saw that all staff received annual appraisals and doctors were able to tell us their individual annual appraisal and revalidation time-frames. Supervision and support arrangements were robust including clinical supervision for the practice nurse.

## Our findings

### Leadership and culture

The practice manager was a key member of the team and contributed significantly to the overall leadership of the practice. The lead GP provided clinical leadership, and promoted a team-approach. Staff that we spoke to said they felt colleagues demonstrated positive values and behaviours on a daily basis. Key partners who worked jointly with the practice to deliver patient care, said the practice was well organised and was very responsive and pro-active in supporting patients care and treatment.

On the day of the inspection, it was clear that staff worked in co-operation with each other to improve the running of the practice. Patients who used the service that we spoke to, said the practice appeared well-run and they said they never witnessed any adverse behaviours or signs that staff did not work well either together as a team or with members of the public.

Most staff had been working at the practice for many years and they all said they were very much committed to working in this local practice. Both GPs had been working at the practice for shorter periods and the steady flow of students, meant there was a balanced organisational culture, combining the best of a traditional general practice with the benefits of a modern approach.

### Governance arrangements

Governance arrangements were clear and relevant policies and procedures, including a statement of purpose, set out designated responsibilities. All staff understood and were able to articulate their roles and responsibilities. Individual practice policies stated who was responsible for delivery of the policy area. For example the lead clinician was responsible for safeguarding adults and children and the practice manager was responsible for staffing matters.

Risks both for patients who used the service, within the clinical environment, and risks to staff were effectively managed. This was achieved through a range of mechanisms including, a risk stratification tool, regular and on-going clinical audits and risk assessments of the physical environment. The practice had a number of mechanisms in place to report and record safety. However,

# Are services well-led?

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

arrangements were not yet sufficient to provide a coherent whole-system picture of safety, which identified themes and ensured consistency of outcomes for patients in comparable population profiles.

### Systems to monitor and improve quality and improvement

The practice manager, business manager and partners held regular practice meetings and these included reviewing the register of all accidents/incidents and significant events which had taken place, including lessons learned from them. There were also on-going checks of the safe running of the practice such as legionella testing, replacing carpets in clinical areas and fire safety.

The practice was not a member of Urgent Health UK (Urgent Health UK validates the quality of care of each member organisation using external audit). However the GP's and the practice nurse, said they regularly had internal clinical meetings. They said these helped them to have healthy conversations about patient care which offered one another 'clinical challenge'. Both GPs also received external peer reviews through annual appraisals.

Comments received by one GP, who was soon due for revalidation, were very complimentary, and emphasised the level of compassion and how thorough patients thought the GP was.

### Patient experience and involvement

A patient participation group (PPG) had been established.

Before the inspection we spoke to a representative of the PPG. During the inspection we met with 10 members of the PPG. The PPG representatives that we spoke to said they had good and effective relationships with practice staff.

Patients said they felt staff listened to their concerns and they were able to identify tangible actions the practice had taken as a result of feedback from the PPG, which demonstrated their impact. There was scope to further increase the numbers of patients contributing to the PPG.

Positively, we noted that the PPG was a very diverse group of patients and reflected the population profile which the practice served.

The practice manager regularly reviewed and responded to comments made about the practice on the NHS Choices and the practices own websites. Where contact details were available, patients were contacted to discuss their experience and also to try to engage them in the PPG.

To increase patient involvement, the practice held an annual coffee morning which coincided with the annual Macmillan coffee morning every year. This event helped to engage patients who lived alone and was helping to reduce isolation. Staff showed us photographs from a recent event.

### Staff engagement and involvement

Staff that we spoke to said they felt very much involved in the running of the practice. Reception staff were kept up to date with developments through weekly meetings with the practice manager as well as ad-hoc day to day supervision.

The practice manager had ensured that reception staff contributed to the conversations about proposed changes to the appointment systems.

We were told that at least once a year all staff gathered for a social event. This was helping to build and maintain effective working relationships.

### Learning and improvement

We spoke with a range of staff who confirmed that they received regular support, supervision and annual appraisals. GPs were aware of the requirements for revalidation. There was a commitment to learn from feedback, incidents and complaints and effective processes were in place to ensure that such learning was shared with relevant staff.

### Identification and management of risk

The practice ensured that risks to the delivery of safe, effective and high quality care were identified and mitigated before they impacted on the quality of care. Risks were discussed at weekly practice and fortnightly MDT meetings and any action recommended or taken was usually logged and always cascaded to all relevant staff.

The practice had a whistleblowing policy and all staff demonstrated awareness of the policy. Staff said they felt sufficiently confident to raise concerns if they arose.

Managers said they routinely had conversations with staff to remind them that if necessary, they could raise concerns with external stakeholders, for example the Clinical Commissioning Group (CCG) or NHS England.

# Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

## Summary of findings

The practice was responsive to the needs of older patients. Patients who completed our comment cards were very complimentary about the quality of care and treatment they received. The surgery was wheelchair accessible and the public toilet had a hand-rail to support patients with mobility problems.

Staff had not received training in the Mental Capacity Act 2005 (MCA).

Many of the patient participation group members (PPG) were older patients and they said they felt their views had been listened to and action had been taken to improve the practice as a result of what they fed-back.

Clinical staff had received training so they could better respond to older patients needs, for example in elderly care or communication with patients experiencing hearing and sight-loss.

## Our findings

The practice was responsive to older people. Older patients in the PPG who completed comment cards said services at the practice were good, very good or excellent.

The surgery was wheelchair accessible and the public toilet had a hand-rail to support patients with mobility problems. The practice held data about its older patients population so it was able to identify and effectively meet patients needs. The practices own data showed that 17% of its patient-list were patients over the age of 75 years. Some 363 of these older patients were registered in a clinical risk group or registered as a family carer.

The practice's own data showed they achieved the highest level of uptake for flu vaccines in their cluster group, with almost 80% of patients aged over 75 receiving the seasonal flu vaccination between (September 2013-January 2014).

Data from the quality outcomes framework (QOF) showed that 80% of those aged over 75 received regular health care reviews to monitor and inform their care and treatment.

Most patients were well known by the practice and we observed a level of friendliness and warmth between patients and staff. All of the patients we spoke to said they trusted practice staff and felt safe in their care. The practice held an annual coffee morning to help engage patients who lived alone and reduce isolation. Staff showed us some of the photo's of the most recent event.

# People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

## Summary of findings

The practice manager used a tool to identify and highlight patients with long-term conditions held on a register. This meant that patients care was regularly monitored and reviewed and patients were invited in for regular check-ups.

The service was responsive to the needs of people with long-term conditions. Staff held registers for patients with long-term conditions such as those with diabetes, heart conditions, dementia, stroke, palliative care and hypertension.

## Our findings

The practice was responsive to patients with long-term conditions. Staff told us that for certain conditions including dementia, cancer and palliative care, family carers or other family members were invited in to informal "chats" with clinicians to discuss any concerns they may have about their loved-one. Where patients with long-term conditions cannot get into the surgery for an appointment clinicians did home-visits to review the patients care.

Staff held registers for patients with long-term conditions such as those with diabetes, heart conditions, dementia, stroke, palliative care and hypertension. The practice manager used a tool to identify and highlight patients with long-term conditions on the registers. Patients care was regularly monitored and reviewed and they were invited in for check-ups. Examples included patients with diabetes being invited in to the foot-clinic. Hypertensive patients were invited in for blood pressure checks.

Quality Outcomes Framework (QOF) indicators showed the practice met 100% of all targets for follow-up reviews concerning patients with asthma, heart failure, chronic heart disease, hypertension and mental health review care plans. We were not able to corroborate this evidence.

The practice had recently started to operate a remote care scheme for hypertensive patients. The scheme enabled patients with hypertension to attend appointments at any-time during opening hours to have their blood pressure taken. We were told that clinicians were then able to discuss the patients results with them immediately, making any adjustments to the persons care and treatment.

# Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

## Summary of findings

The practice was responsive to mothers, babies and young patients. The practice had a second reception area dedicated to expectant or new mothers. This meant that mothers could, for example, breast-feed their baby, weigh or change the baby in privacy.

All staff had received training in safeguarding children and had a good awareness of the signs of possible abuse.

## Our findings

The practice was responsive to mothers, babies and young people. Staff recognised that some, in particular, first-time mothers felt isolated and staff said they tried to help mothers to interact with each other while waiting in reception. Staff said this was helping some mothers to establish friendships, reduce isolation and find mutual support.

Post-natal care was provided and staff said that all new mothers were invited for a check-up of both themselves and their new baby six weeks after delivery. Staff said that sending the mother an appointment reduced the risk of the new mother over-looking the need to attend this important check-up.

The practice's own data showed that it performed well against national childhood immunisation targets. During the period 2013-2014 the practice carried out 97.1% of childhood immunisations. For the same period 97.9% of pre-school immunisations were carried out by a dedicated practice nurse.

Staff said they ensured that children and young patients were offered appointments to fit-in with their school day. Clinical staff said that if a young person was accompanied by a responsible adult, but wanted to speak to staff in confidence for example, about contraception or other advice, they helped to make this happen.

# Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

## Summary of findings

The practice was responsive to the needs of the working-age population and those recently retired. The service offered appointments early in the morning and late evening to suit patients who were of working age or recently retired. A doctor offered telephone triage and where necessary re-directed patients to appropriate appointments. Through regular review of staffing levels and use of a regular locum doctor, the practice manager worked alongside reception staff, ensured that sufficient numbers of appointments were made available on a daily-basis.

## Our findings

The practice was responsive to the needs of the working-age population and those recently retired. All the patients that we spoke with before and during the inspection, said they were satisfied with the arrangements for making an appointment and they said they could get an appointment when they needed it. This was of particular importance for working age patients because they often couldn't attend surgery during the day due to work commitments.

The surgery had a website which enabled on-line prescription requests, but patients couldn't yet book appointments on-line. There was a texting facility to remind patients about appointments or to let them know about wider NHS health promotion activity, for example flu vaccine reminders. The practice's own data showed they achieved over 85% take-up for flu vaccines to the over 65 age group and they achieved 98% take-up for cervical smear testing of 25-64 year olds.

# People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

## Summary of findings

The practice was responsive to the needs of patients in vulnerable circumstances who may have poor access to primary care. Where they were aware of patients in vulnerable circumstances they said they were flexible in their approach, for example registering patients irrespective of whether they had a permanent residential address or not. The practice had more to do to identify patients in vulnerable circumstances.

## Our findings

The practice was responsive to the needs of patients in vulnerable circumstances who may have poor access to primary care. Currently, the practice had identified very small numbers of patients who were homeless or from traveller-communities. Staff said that they never turned patients away because of their vulnerable circumstances, including if they did not have a stable residential address.

Staff gave accounts about how they had tried to engage with patients known to them who were in vulnerable circumstances.The practice had identified 12 patients who used the service who had a learning disability. Annual health check were carried out for all patients with a learning disability, ensuring that patient care and treatment was reviewed. Staff said they placed significant importance on supporting families who were caring for patients with complex needs. This helped to reduce isolation and carer burden.

# People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

## Summary of findings

The practice was responsive to the needs of people experiencing poor mental health. The practice engaged with patients experiencing poor mental health to ensure that regular physical health checks were carried out. This meant the patients care, treatment and medication could be monitored and reviewed.

## Our findings

The practice was responsive to the needs of patients experiencing poor mental health. The practice had identified 36 patients with poor mental health. Patients details were held on a register to ensure their needs were well known by clinicians and to ensure they received timely follow-up. Staff recognised they were supporting an increasing number of patients with poor mental health and that ensuring these patients were effectively supported by the wider multi-disciplinary team was essential. The practices own data showed that 25 of the 36 patients with poor mental health, had received a yearly physical health check and they had a care plan in place.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010<br><br>Consent to care and treatment<br><br>How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of services users in relation to the care and treatment provided for them. This was because staff had not been trained in the requirements of the Mental Capacity Act (2005)<br><br>Regulation 18 |

| Regulated activity | Regulation |
|---|---|
| Family planning services | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010<br><br>Consent to care and treatment<br><br>How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of services users in relation to the care and treatment provided for them. This was because staff had not been trained in the requirements of the Mental Capacity Act (2005)<br><br>Regulation 18 |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010<br><br>Consent to care and treatment |

This section is primarily information for the provider

# Compliance actions

How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of services users in relation to the care and treatment provided for them. This was because staff had not been trained in the requirements of the Mental Capacity Act (2005)

Regulation 18

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010<br><br>Consent to care and treatment<br><br>How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of services users in relation to the care and treatment provided for them. This was because staff had not been trained in the requirements of the Mental Capacity Act (2005)<br><br>Regulation 18 |