Stockwell Lodge Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
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?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Stockwell Lodge Medical Centre on 4 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the each of the six population groups we looked at. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks and infection control.
- Data showed patient outcomes were average for the locality. We saw no evidence that clinical audits had been carried out to improve patient outcomes.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested.
- The practice had a number of policies and procedures to govern activity, but some of these had not been reviewed.

The areas where the provider must make improvements are:

- Ensure that all nursing staff have a criminal records check through the Disclosure and Barring Service (DBS). Where non-clinical staff perform chaperone duties, the practice must risk assess whether a DBS check is required.

In addition the provider should:

- Carry out infection control audits periodically.

Summary of findings

- Implement a programme of clinical audits to evaluate and improve the quality of services provided.
- Maintain accurate and complete training records.
- Support staff through regular, scheduled appraisals relevant to the work they perform.
- Implement a system to ensure that blank prescriptions are tracked through the practice and kept secure at all times, as required under the NHS Protect Guidance, August 2013.
- Ensure all out of date policies and procedures are reviewed and up to date.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. The practice had an infection control policy and a member of staff was appointed infection control lead but no infection control audits had been carried out. The practice did not implement adequate pre-employment recruitment checks including Disclosure and Barring Service checks on all nursing staff and those performing chaperone duties.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles. However the practice did not have a complete record of up to date training certificates for all levels of staff to evidence that all essential training courses had taken place.Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice comparably with 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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Information was available to help patients understand the services available to them. The practice sent condolence cards to recently bereaved patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The patient participation group (PPG) informed us improvements had

Summary of findings

been made to the appointment system to improve access. The practice had good facilities and was well equipped to treat patients and meet their needs. 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 with staff and other stakeholders took place.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. Some of the policies required a review but there were plans in place for this. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

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

Good

The practice is rated as good 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 and rapid access appointments for those with enhanced needs. The practice worked closely with a local residential home and visited it monthly to review all patients' care plans in addition to daily home visits when required.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Longer appointments of up to 30 minutes were available and home visits were carried out when needed. All housebound patients had an alert on their patient record to ensure they were offered a home visit. All people with long-term conditions 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There was a safeguarding lead to support staff to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. 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. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

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

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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 of this age group. The practice offered early morning and evening appointments for patients who were not able to attend the surgery during normal day time hours. Telephone consultations were also available for those patients unable to attend the practice for a face to face appointment.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. 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. Patients with a learning disability were supported to make decisions through the use of care plans.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients with dementia were supported to make decisions through the use of care plans. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. The practice was working with the NHS England Area Team and Clinical Commissioning Group (CCG) on a proposal for a shared care protocol for dementia prescribing.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to provide us with feedback on the practice. We received six completed cards. Five of these were positive about the service experienced. Patients said they felt the practice offered a good service and they felt listened to. There was one positive comment on the availability of early morning appointments. There was one comment regarding dissatisfaction with the care received and difficulty getting through to the practice on the telephone.

Prior to the inspection we spoke to a member of the patient participation group who stated that improvements were being made by the practice and it listened to feedback. The group had noticed an improvement to the appointments system.

The data from the 2014 National Patient Survey was reviewed. The satisfaction rates were lower than expected for this practice for a number of aspects of care but similar to expected for others. For example, only 55% of respondents stated that the GP was good or very good at treating them with care and concern whereas this rose to 85% in respect of the experience of the treatment by the nurses.

Areas for improvement

Action the service MUST take to improve

• Ensure that all nursing staff have a criminal records check through the Disclosure and Barring Service (DBS). Where non-clinical staff who perform chaperone duties, the practice must risk assess whether where they may be left alone with a patient must also have a DBS check is required.

Action the service SHOULD take to improve

• Carry out infection control audits periodically.

• Implement a programme of clinical audits to evaluate and improve the quality of services provided.

• Maintain accurate and complete, up to date training records. and keep copies of training certificates.

• Support staff through regular, scheduled appraisals relevant to the work they perform.

• Implement a system to ensure that blank prescriptions are tracked through the practice and kept secure at all times, as required under the NHS Protect Guidance, August 2013..

• Ensure all out of date policies and procedures are reviewed and up to date.

Stockwell Lodge Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP acting as a specialist adviser.

Background to Stockwell Lodge Medical Centre

Stockwell Lodge Medical Centre provides a range of general medical services to people in Cheshunt, Hertfordshire. The practice population is of mixed ethnic background and is classed as being a less deprived area. The practice has a list size of 13,200 patients.

The contract held by Stockwell Lodge Medical Centre is a GMS contract. General Medical Services (GMS) agreements are a nationally directed contract between NHS England and a practice.

Clinical staff at the practice includes four GP partners and two salaried GPs, four male and two female. There is a nurse practitioner, a practice nurse and two health care assistants. The practice also has a number of reception and administration staff led by a practice manager and a reception manager.

The practice has opted out of providing out-of-hours services. This service is provided by the principal local out-of-hours provider and can be accessed by telephoning them direct on a number obtained from the practice answerphone or via the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We spoke to the local residential care home and the chairperson of the patient participation group. We carried out an announced visit on 4 March 2015. During our visit we spoke with a range of staff including GPs, nursing staff, the practice manager, reception and administration staff. We also spoke with patients who used the service and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The practice manager told us all staff were encouraged to report incidents. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 18 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 18 months and we were able to review these. They showed that events were recorded, analysed and recommendations made to improve practise and prevent recurrence. Significant events was a standing item on the weekly practice clinical meeting agenda. We saw that significant events and complaints were reviewed each year to identify trends and learning. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms from the practice intranet or completed a hard copy form and sent them to the practice manager. They showed us the system used to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a process had been put in place to ensure patients with abnormal test results were seen the same or next day.

National patient safety alerts were disseminated by the administration team to practice staff by email. If an urgent action was required this was highlighted to the duty doctor. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us that if any actions were needed the alerts were discussed at the weekly clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff informed us that they had received relevant role specific training on safeguarding children but not for vulnerable adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to a more advanced level to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans had information added to a management box to highlight that a plan was in place.

A chaperone policy was in place and available for staff to read and there was a notice in the reception area informing patients of this. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff, including health care assistants, and reception staff informed us they had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Requires improvement

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and were able to describe what they would do in the event of a failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that showed prescribing and medicines management was a standing item on the clinical meeting agenda.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they informed us they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. There was no process in place to ensure that blank prescriptions were tracked through the practice and kept securely at all times in accordance with national guidance. As a result, the practice could not be assured they had limited the risk of blank prescriptions being used improperly.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead member of staff for infection control. The lead staff member informed us that no infection control audits had been carried out therefore the practice were not able to identify any actions or improvements required.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. However the policy's review date was overdue. The practice manager had planned to review all policies as they were transferred to a new computer system. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of October 2014. A schedule of testing was in place and we saw a record of items that had failed the testing showing they had been disposed of. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure measuring devices.

Staffing and recruitment

We looked at five staff records and found that some recruitment checks had been made prior to employment but there was no evidence that any of the clinical or non-clinical staff had a criminal records check through the Disclosure and Barring Service (DBS). The practice informed us that DBS checks had not been carried out on any of their staff. Some of the records we looked at contained evidence that proof of identification, references, qualifications, registration with the appropriate professional body had been taken but not all records

contained all the checks. The practice had a recruitment policy that had recently been developed and implemented. The policy set out the standards the practice should follow when recruiting clinical and non-clinical staff.

The practice manager had recently completed a staffing needs analysis and scheduled the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see. The practice manager and a health care assistant were the identified health and safety representatives. We saw that health and safety was a standing item on the practice meeting agenda.

The practice did not have a formal risk log but we were informed that there were plans to implement one. Identified risks were included within the policies and procedures with mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that the majority of staff had received training in basic life support. One clinician and three administration staff were due to attend the training in May 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, hypoglycaemia and seizures. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Mitigating actions were recorded to reduce and manage the risk. Risks identified included power failure, loss of telephony and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. Staff were able to access the document on the practice intranet and we were informed that a copy of the plan was held off site at the homes of two of the practice staff.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff practised fire drills every three months. Staff informed us that they were up to date with fire training but no certificates were available for us to view to evidence this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs told us that any new guidelines or changes to protocols were discussed at clinical meetings. They were able to provide a recent example of this which was the change in chronic obstructive pulmonary disease (COPD) management. We saw minutes of practice clinical meetings where the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma. There was also a lead GP for palliative care. The practice nurses supported this work and reviewed patients with asthma, COPD and diabetes which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they met daily at lunch times to discuss any clinical problems they had encountered. Our review of the clinical meetings minutes showed that the practice made plans for each GP to present a topic at the clinical meetings on a rotational basis.

A GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing. This data, and the national data available to the CQC, showed that the practice was similar to other local practices in its antibiotic prescribing rates. The practice reviewed patients with chronic diseases in line with the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data showed they were achieving targets in line with the local CCG. Patients with complex needs had multi-disciplinary care plans documented in their case notes and were discussed at multi-disciplinary team meetings. We were shown the process the practice used to review patients recently discharged from hospital. This required the discharge summary from the hospital to be reviewed and the patient seen by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers who were referred and seen within two weeks.

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

Management, monitoring and improving outcomes for people

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

We noted that there was no expectation for clinical staff to undertake clinical audits. On discussion with the GP partners it was recognised that clinical audits should be introduced at the practice. A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. The only audits performed where improvement was documented related to medicines management information. For example, following a medicines alert regarding the prescribing of a combination of two specific medicines, patients at risk were identified. The GPs carried out medication reviews for these patients and altered their prescribing practice in line with the guidelines. The practice had also carried out an audit related to appropriate antibiotic prescribing.

The practice also used the information collected from the QOF about their performance against national screening programmes to monitor outcomes for patients. For example, 95% of patients with diabetes had an annual foot

Good

Are services effective?

(for example, treatment is effective)

examination which was comparable with other practices in the locality. The practice was above the local CCG average for all areas of QOF except for the assessment and review of patients with depression.

The team was making use of clinical supervision and staff meetings to assess the performance of clinical staff. The GPs we spoke with said they peer reviewed colleagues' performance by seeing each other's patients and highlighting and discussing problems. Staff told us the focus in the practice was on achieving high QOF results, thereby providing a positive outcome for patients.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice computer system flagged up relevant medicines alerts when the GP was prescribing medicines. The practice also used a system that suggested alternatives to prescribing to ensure cost effective medicines were used. The GPs told us that if they continued to prescribe a medicine following an alert they would document their rationale for doing so.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The patients on the register were given priority access to the practice by use of a separate telephone number. The reception manager worked with the palliative care lead GP to ensure that all suitable patients were on the register. This included those with end stage chronic illnesses and terminal cancers.

The practice informed us that all housebound patients had an alert on their patient record. This ensured that if they needed to see a GP they were automatically offered a home visit.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The practice had also spent time observing and learning from other practices in the locality with a specific emphasis on improving patient access.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice did not have a complete record of up to date training certificates for all levels of staff to evidence that all essential training courses had taken place. Therefore, the practice could not be assured that all staff were sufficiently competent to carry out their roles.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). As we have reported above, there was no evidence that GPs were carrying out clinical audits however in order for GPs to be revalidated they are required to carry out a clinical audit every five years

The practice informed us that they aimed to appraise all staff annually however the staffing records showed that no one had received an appraisal in the past year. We did not see any plans for an appraisal schedule for the coming year. Therefore the provider could not be assured that staff were performing as they should and staff had no means of discussing their development

The practice nurse and nurse practitioner were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines and cervical cytology. They also had extended roles seeing patients with long-term conditions such as asthma, COPD and diabetes. They were able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the NHS 111 service both electronically and by post. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. We saw, on the significant event log, that within the last year there had been one instance when blood test results were

Good

Are services effective?

(for example, treatment is effective)

not reviewed as the GP had been on leave. Systems had been put in place to ensure that all results and communications were seen by a GP working on the day they were received.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children subject of child protection plans. These meetings were attended by district nurses, palliative care nurses and members of the Home First team. The Home First team supported older people and others with long term or complex conditions to remain at home rather than go into hospital or residential care. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

A GP from the practice visited a local residential care home each month, in addition to requested home visits, to review all patients and ensure their records and care plans were up to date. This was confirmed by the care home.

Information sharing

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

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. A summary record was also taken by the GP when they did a home visit in case a hospital admission was indicated. The practice had also signed up to the electronic Summary Care Record which provided faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. All clinical staff demonstrated a clear understanding of the Gillick competency test. (This test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with a health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. For example the health care assistant would inform the GP if they noted a patient had a high blood pressure recording. The GPs told us they offered opportunistic chlamydia screening to patients aged 18 to 25 years and smoking cessation advice to smokers.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. These health checks were done by a health care assistant with any patient with risk factors for disease identified referred to a GP to schedule further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all of these patients were offered an annual physical health check. The practice had also identified the smoking status of 92% of patients over the age of 16 and actively offered smoking cessation advice to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 87%, which was comparable to others in the CCG area.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. The data from the 2014 National Patient Survey was reviewed. The satisfaction rates were lower than expected for this practice for a number of aspects of care but similar to expected for others. For example, only 55% of respondents stated that the GP was good or very good at treating them with care and concern whereas this rose to 85% in respect of the experience of the treatment by the nurses. The practice was also rated below average with 48% of respondents who rated the practice as good or very good. The practice was also below average for its satisfaction scores on consultations with doctors and nurses. Sixty percent of practice respondents said the GP was good at listening to them and 54% said the GP gave them enough time.

The most recent practice patient participation group survey (PPG) dated 2014 looked at communication and access to test results. A previous survey in 2013 showed that patients were generally satisfied with the care received from the nursing staff. Of the 214 responses 97% said the nurse took time to listen to their problem and 95% said they felt their issues were addressed effectively.

Patients completed CQC comment cards to tell us what they thought about the practice. We received six completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and one commented that the staff were helpful. One comment was less positive and two stated they had difficulty getting through on the telephone. We also spoke with five patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One of the patients commented that they couldn't always get an appointment with the same GP.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located behind the reception desk. The practice informed us that they had used glass partitions to keep patient information private but they had removed them at the request of the patient participation group. During the inspection we could not overhear conversations on the telephone from the reception area.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

We saw an action plan put in place following a recent NHS England Area Team and CCG meeting that showed the practice had planned to improve the patient experience at the practice. The action plan also showed plans to improve the practice's approach to complaints management and patient feedback.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice poorly in these areas. For example, data from the national patient survey showed 47% of practice respondents said the GP involved them in care decisions and 52% felt the GP was good at explaining treatment and results. Both these results were below average compared to other practices nationally.

Patients we spoke with on the day of our inspection were more positive about the practice and told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Most of the 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 patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

Notices in the patient waiting room and on the patient website told patients how to access a number of support groups and organisations. For example Asthma UK and Macmillan Cancer Support. The practice's computer system alerted GPs if a patient was also a carer. There was information in the waiting room about Crossroads Care, a support organisation for carers and a local carer's café. This provided information for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, the practice would send them a condolence card. A patient consultation at a flexible time and location to meet the family's needs was offered.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient'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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example there was a proposal for a shared care protocol for dementia prescribing with other practices in the area.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG told us one of these changes was a review of the appointments system with same day face to face appointments offered in addition to telephone triage. Patients were also able to book an appointment online through the practice website.

The practice informed us they offered appointment slots of up to 30 minutes for patients with long term conditions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had a register of carers. Patients who were carers were offered additional support and advice as required. They were also offered an annual flu vaccination. The practice informed us that patients with learning disabilities were offered an annual health check and longer appointment times.

The practice had access to online translation services and planned to commission a telephone translation service. A number of the practice staff were multi-lingual and would translate if required.

We did not see any evidence that the practice provided equality and diversity training for its staff.

The premises and services had been adapted to meet the needs of patients with disabilities. We saw that there were ramps to access the building and double entrance doors. The waiting area was large enough to accommodate patients with wheelchairs and prams. Some of the corridors were narrow but still wide enough for wheelchairs. All the consulting rooms were situated on the ground floor with the first floor used for administration staff. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There were two reserved parking bays for disabled patients at the entrance to the surgery.

Access to the service

Appointments were available from 9am to 12pm and 2pm to 6.10pm on weekdays. There were some early morning and evening appointments available for patients who were not able to attend the surgery during normal day time hours, these were from 7.30am to 8am and 6.30pm to 8pm Monday to Wednesday.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to one local residential care home daily as required and to those patients at home who needed one.

The practice informed us that access to appointments had been a common source of negative feedback from their patients. The practice manager had completed a demand and capacity analysis to ensure optimum appointment availability when needed. We saw an action plan that showed more slots had been made available for same day appointment requests. Feedback from the patient participation group (PPG) informed us they had noticed an improvement and patients could generally book an appointment on the same day.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice's extended opening hours on Monday to Wednesday was particularly useful to patients with work commitments. This was confirmed by one patient who had completed a comment card stating they were pleased they could book an appointment at 7.30am.

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. There was a complaints manager and a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice website and in the practice information leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at all complaints received in the last 12 months and found they had been satisfactorily handled. Learning points had been documented and feedback given to staff when required. We saw apologies had been made to patients when appropriate.

All complaints were discussed at the practice clinical meetings when they arose. The practice manager informed us they planned to review all complaints with the GP partners every six months to help identify trends. Identified trends from complaints documented in the past 12 months were telephone access and availability of appointments. We noted that these issues had been addressed and the practice manager informed us there had been a recent decline in this theme of complaint. We saw evidence of this decline on the practice complaint log.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practise did not have a business plan or vision documented, but staff we spoke with informed us they aimed to provide healthcare and help for patients in a stress free way. The practice statement of purpose only stated they aimed to provide GP services for patients under the GMS contract. The practice website contained information for patients on the practice's plans for the next year. This included the promotion of online appointment and prescription booking and the introduction of summary care records.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of these policies and procedures and found that some of them including the infection control policy and the vulnerable adult policies were past their review date, however, the information they contained was relevant. The practice manager informed us they planned to introduce a new computer system that would contain all the policies in one place and highlight when a review of individual policies was required.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. The members of staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had not carried out criminal records check through the Disclosure and Barring Service (DBS) for the nursing staff. Also there were no DBS checks for non-clinical staff performing chaperone duties who may be left alone with a patient.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The nurse practitioner told us about a local clinical supervision group they attended. The nurse practitioner was the chair person for the group and nurses and health care assistants from local practices attended. We saw minutes of the meetings and noted that they were held every six weeks. Clinical supervision enables clinicians to reflect on their practice. It aims to identify solutions to problems, improve practice and increase understanding of professional issues.

We found no evidence of an on going programme of clinical audits to enable the practice to monitor quality and systems or to identify where action should be taken. On discussion with the GP partners it was recognised that clinical audits should be introduced at the practice. We did observe the practice performed audits in response to medicines management; for example, the review of patients with reduced renal function receiving a diabetic medication.

The practice had arrangements for identifying, recording and managing risks. There was not a formal risk log in the practice but minutes from the practice meetings showed that risks were discussed and any actions were communicated to staff.

The practice held weekly clinical meetings that incorporated governance. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, the training policy, recruitment policy and induction procedure, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the patient participation group (PPG) patient survey for 2014 which focussed on electronic communications and accessing test results. The results showed 81% of respondents knew how to access their test results with 80% stating it was easy. It was agreed the GPs would pilot the use of text messaging to communicate results to patients.

The practice had an active PPG, a group of patients registered with the surgery who have no medical training but have an interest in the services provided. The PPG recognised that the group predominately included members from the older population and said they would like to attract younger members. They felt that the daytime scheduling of meetings had an impact on this. The group met monthly with representatives from the practice and carried out regular surveys. Results from the surveys, information about the group and newsletters they produced were available to view on the practice website.

The practice had gathered feedback from staff through staff meetings and discussions. Staff informed us that there was an open culture within the practice and they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice informed us that staff had yearly appraisals. We looked at five staff files but there was no evidence of appraisals carried out in the past 12 months. Staff told us that the practice was supportive of training and that guest speakers and trainers from the local CCG attended the practice. However the practice did not keep a record of training for all levels of staff, or have certificates to prove that all training had taken place.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, a process had been implemented to ensure all pathology results were seen in a timely manner.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not operate effective recruitment procedures in order to ensure persons employed for the purposes of carrying out the regulated activities were of good character. This was because Disclosure and Barring checks (DBS) had not been made on all nursing staff and those non-clinical staff carrying out chaperone duties.** **This was in breach of regulation 21 (a) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**