Dr De & Dr A Ghosh Brace Street Health Centre

Quality Report

Brace Street Health Centre
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Date of inspection visit: 20 October 2014
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Dr De and Dr A Ghosh Brace Street Health Centre Practice on 20 October 2014. The practice is partnership of two GPs providing primary medical services for a population of approximately 3000 patients. The practice serves a diverse population in one of the most deprived areas in the country.

We found that the practice was responsive but needed to improve to deliver a safe, effective, caring and well-led service. We rated the practice overall as requires improvement.

Our key findings were as follows:

- Systems in place were not robust to ensure patients received a safe service. Potential risks to performance and patient safety (including those relating to health and safety, infection control, safe staffing, equipment and medicines) were not well managed.
- The practice did not have effective processes in place to drive service improvements and performance for patient outcomes.
- Feedback from patients about the service were mixed in their experiences of care and treatment received. Although most patients spoke positively of the service there was some scope for improvement. There had been efforts by the practice to improve the customer services aspect of care and maintain privacy which had been noticed by some patients.
- The practice was responsive to the needs of its patients. Patients expressed satisfaction with the appointment system. They were able to make an appointment easily and if needed could get urgent appointments the same day. The practice was accessible to patients with mobility difficulties.
- The practice did not demonstrate clear leadership and direction. The governance arrangements were not clearly defined so as to effectively manage risks and performance.

However, there were areas of practice where the provider needs to make improvements.

Summary of findings

Importantly, the provider must:

- Ensure staff undertaking chaperoning duties have a clear understanding of their role and duties in order to appropriately support the patient during examination.
- Ensure that effective governance arrangements are in place for monitoring and managing potential risks to patients' safety and performance relating to patient outcomes. This would include the issues relating to health and safety, staff recruitment and staffing levels, maintenance of equipment and medicines.

In addition the provider should:

- Strengthen the processes for managing information relating to patient safety and care. For example incidents, safety alerts, national guidance, audits complaints and comments and performance data to ensure that action needed is clearly identified and carried out to deliver improved patient outcomes.
- Introduce formal arrangements to ensure the needs of patients with complex and end of life care are discussed with relevant health and care professionals and co-ordinated care is delivered. This should include sharing information where appropriate with other providers such as the out of hours services to ensure patients receive continuity of care.
- Ensure staff understand their responsibilities under the Mental Capacity Act 2005 and their duties in fulfilling it.
- Establish systems to support patients who have recently suffered bereavement.
- Improve systems to support people who may be more vulnerable to access primary medical services.

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 safe as there are areas where improvements must be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Lessons learnt were communicated to staff to support service improvement, although reporting of incidents was not always sufficiently detailed to demonstrate a thorough investigation had taken place. Some risks to patients who used the service were assessed but systems and processes to address risks were not implemented well enough to ensure patients were kept safe. For example, staff acting as a chaperone did not have a good understanding of their duties, issues relating to infection control had not been picked up in the infection control audit, there were no risk assessments in place in relation to the absence of disclosure and barring service (DBS) checks for non-clinical staff or for the availability of some emergency medicines.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective as there were areas where improvements must be made. Knowledge of and reference to national guidelines was inconsistent. The practice gave some examples as to how patient's needs were assessed and care planned but was not always able to provide evidence of this. Audits undertaken were not consistently completed and did not demonstrate that they were driving improvement in performance for patient outcomes. Some multi-disciplinary working was reportedly taking place but was generally informal and the record keeping was absent. Staff received appropriate training although chaperoning was identified as an area for staff development. Some staff had received appraisals within the last 12 months of their performance and to identify training needs but not all.

Are services caring?

Requires improvement

The practice is rated as requires improvement for caring as there are areas where improvements should be made. Data showed patients rated the practice lower than others for some aspects of care. The majority of patients said they were treated with compassion dignity and respect. However not all felt cared for, supported and listened to. Accessible information was available to help patients understand the care available to them, although this could be better extended

Summary of findings

to meet the needs of the local population. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Following feedback the practice had actively sought to improve this aspect of patient care.

Are services responsive to people's needs?

Good

The practice is rated as good. The practice was engaged with the NHS Local Area Team and Clinical Commissioning Group (CCG) to review information about the local population and to secure service improvements. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. In most instances the practice was equipped to treat patients and meet patient need however there was room for improvement for responding to the needs of vulnerable patients and those with complex needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was some evidence of shared learning internally.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The practice did not have a clear vision and a strategy to deliver this. Staff understood their individual roles and responsibilities with the day to day running of the service. The leadership within the practice was not clear, the manager's role was not clearly integrated with the clinical team and clinical leadership was not apparent. The practice had a number of policies and procedures to govern activity and these were up to date. However the governance arrangements were not sufficiently robust to ensure risks to patients were being effectively managed and to deliver service improvements. The practice sought some feedback from patients but did not currently have an effective patient participation group (PPG) to support the service. Staff felt supported by their colleagues and felt able to raise issues or concerns if they needed to. Some staff had received annual appraisals of their performance but not all.

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.

The practice had a lower than average proportion of patients over 75 years than the national average. The practice offered annual health checks for patients over 75 years and testing for dementia. This enabled the onset of health conditions to be detected and managed at the earliest opportunity. Elderly patients were able to see a GP when they needed to and the practice was accessible to patients with mobility difficulties.

The practice did not have any specific systems in place to identify older patients with multi-morbidities and complex health needs. There were no multi-disciplinary team meetings in place to ensure those with complex care needs, including patients at the end of life, were managed in a co-ordinated way.

People with long term conditions

Requires improvement 

The practice is rated as requires improvement for the population group of people with long term conditions.

Patients with long term conditions were reviewed by the GPs and the practice nurses to assess and monitor their health condition. This enabled any changes in the patient's condition to be managed as appropriate. Patients were invited to attend by telephone contact or opportunistically. Home visits were available if patients were unable to attend the surgery and urgent requests for appointments were triaged so that if the patient needed an appointment they would be seen. There had been two incidents in the last 12 months involving prescriptions not being available when needed but these had been addressed through training and staff demonstrated a good awareness of managing repeat prescriptions. The practice pharmacist undertook medicine reviews of more complex patients. Links to information on a range of conditions was available on the practice website.

The practice had difficulty providing information as to how it was performing in terms of outcomes for managing patients with long term conditions. The latest Quality Outcomes Framework (QOF) data (a national performance tool for patient outcomes) showed that performance varied according to condition. Diabetes was identified as an area where the practice performed less well. We were told this was a cultural issue and that notices had been put in place to

Summary of findings

encourage Asian diabetic patients to attend the surgery. The practice did not have multi-disciplinary team meetings or specific care plans in place to discuss and co-ordinate care for those with the most complex care needs.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people.

The practice had a higher than average proportion of younger patients than the national average. Young children were able to see a GP when they needed to and the practice was accessible to pushchairs. Appointments were available outside school hours on most evenings. Links were available to information on child and teenage health via the practice website.

There were systems in place for identifying children living in disadvantaged circumstances and who were at risk. Alerts on the patient record system enabled staff to identify and be extra vigilant of those who were at risk. All staff had received training in safeguarding children and had support from a lead GP for safeguarding so that appropriate action could be taken if they were concerned a child may be at risk of harm. The midwife and health visitor operated clinics once per week at the practice which enabled informal discussions to take place to share information or concerns.

Immunisation rates were lower than other practices in the Clinical Commissioning Group (CCG). The practice was unable to provide any updated information about immunisations but told us they had carried out additional clinics to follow up patients who had not attended.

Working age people (including those recently retired and students)

Good

The practice opened extended hours on two evenings each week until 7.10pm to accommodate the needs of working age patients. Patients were able to book non urgent appointments in advance as well as on the day. Telephone consultations were available on request if the patient was unable to attend the practice. The practice had not yet introduced on-line booking for appointments and prescriptions but had plans to do so.

Students who were already registered with another practice were able to register as temporary residents if they needed to receive health care support. There were links to a range of health information relating to men and women on the practice website which patients could review at their convenience.

Summary of findings

At the time of the inspection the practice did not offer NHS health checks. There were however plans to offer this service and clinical staff had received training in preparation to undertake these checks. Some screening programmes were offered at the practice but health promotion clinics such as smoking cessation and weight loss were not available.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people whose circumstances make them vulnerable.

The practice held a register for some vulnerable groups such as patients with learning disabilities and could identify patients who were at risk. Staff had received training and had an understanding of how to recognise and what action to take if they were concerned a patient may be at risk of harm.

Annual health checks were available for patients with learning disabilities but only one out of seven had been completed in the last 12 months. Multi-disciplinary team working to support vulnerable patients with complex care needs was limited. The practice required patients to have an address before they could register and were not able to confirm how they would manage a patient with no fixed abode as they had not come across this situation before.

People experiencing poor mental health (including people with dementia)

Requires improvement

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

The practice used specific screening tools to identify patients with mental health problems and dementia so that patients could be appropriately referred. We saw evidence of health reviews for patients with poor mental health including reviews of their medicines. The practice had difficulty identifying the percentage of patients experiencing poor mental health who had received an annual physical health check. However, there were links to a range of information on mental health conditions on the practice website including details of various mental health support groups including MIND and SANE.

The practice did not specifically work with multi-disciplinary teams in the case management of patients experiencing poor mental health or have advanced care plans for patients with dementia.

Summary of findings

What people who use the service say

We spoke with five patients who were registered at the practice either in person or by telephone; this included a member of the practice's Patient Participation Group (PPG). The PPG is a way in which patients and practices can work together to improve the quality of the service provided. We also reviewed the 35 comment cards provided by CQC which had been completed by patients who had recently used the service.

The feedback and comments we received about the practice were mostly positive. Patients told us that they were generally satisfied with the service they received. They told us the staff were friendly and helpful and that they felt listened to. Seven patients, although happy with the practice raised some issues. Three patients told us that there was a lack of privacy at the reception desk and conversations could be overheard, two patients told us they had difficulties getting an appointment when they wanted one and two related to their specific treatment and advice.

We also looked at feedback from patients and others about this practice. This included feedback from the national GP patient survey carried out in 2013. Results from the GP patient survey were similar to other practices in terms of opening hours and making appointments but worse in terms of satisfaction.

Areas for improvement

Action the service MUST take to improve

- Ensure staff undertaking chaperoning duties have a clear understanding of their role and duties in order to appropriately support the patient during examination.
- Ensure that effective governance arrangements are in place for monitoring and managing potential risks to patients' safety and performance relating to patient outcomes. This would include the issues relating to health and safety, staff recruitment and staffing levels, maintenance of equipment and medicines.

Action the service SHOULD take to improve

- Strengthen the processes for managing information relating to patient safety and care. For example incidents, safety alerts, national guidance, audits complaints and comments and performance data to ensure that action needed is clearly identified and carried out to deliver improved patient outcomes.
- Introduce formal arrangements to ensure the needs of patients with complex and end of life care are discussed with relevant health and care professionals and co-ordinated care is delivered. This should include sharing information where appropriate with other providers such as the out of hours services to ensure patients receive continuity of care.
- Ensure staff understand their responsibilities under the Mental Capacity Act 2005 and their duties in fulfilling it.
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- Improve systems to support people who may be more vulnerable to access primary medical services.

Dr De & Dr A Ghosh Brace Street Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP Specialist Advisor, a practice manager specialist advisor and a second CQC inspector.

Background to Dr De & Dr A Ghosh Brace Street Health Centre

The practice provides General Medical Services to a population of approximately 3000 patients. It is located in a health centre which is shared with another GP practice and community based health services. The practice is situated in an area with high levels of deprivation and is in the most deprived areas nationally. The population is younger than the national average.

The practice is open Monday to Friday 9am to 6.30pm, with the exception of Wednesday afternoon. Extended opening hours are available on two evenings, Monday and Thursday, until 7.10pm. The practice has opted out of providing out-of-hours primary medical services to another provider.

Dr De is a female GP and Dr Ghosh a male GP. A practice nurse is also employed full time along with several administrative staff.

Why we carried out this inspection

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?

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

- Older people

Detailed findings

- People with long-term conditions
- 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 carried out an announced visit on 20 October 2014. During our visit we spoke with a range of staff including a GP partner, the practice nurse and three reception staff. We also looked at a range of documents that were made available to us relating to the practice.

We spoke with patients who visited the practice and observed how staff interacted with them. We reviewed comment cards where patient and members of the public shared their views and experiences of the practice. We spoke with a former member of the practice's Patient Participation Group (PPG). The PPG is the way in which practices can work with patients to improve the services provided.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, as well as comments and complaints received from patients.

There was no evidence of any formal arrangements for routinely discussing safety information. The practice manager told us that clinical meetings were held but could not confirm what was discussed at these meetings and there were no records of these meetings available. Information received relating to patient safety tended to be managed on an individual basis. There was no evidence that information relating to safety was reviewed in order to identify any emerging themes or trends.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, we saw an incident report in which patient information had been scanned into the wrong patient records. Whilst the incident was acted on and discussed with staff, there was little evidence to show that it had been investigated to determine whether the incident could have been avoided and future reoccurrence prevented.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and acting on significant events, incidents and accidents. Records were kept of significant events that occurred during the last two years and these were made available to us. Staff told us that they would report any incidents to the practice manager who completed the incident report form and over saw the management and monitoring of the incident. We saw from the minutes of practice meetings where learning from incidents had been discussed.

We looked at the five incident forms that had been completed since October 2012. We found that incident reports were not always comprehensively completed. The reports did not routinely show how the incident had been investigated in order to identify how it had occurred and whether it could have been prevented. However, we saw action was taken in response to incidents in a timely manner. For example, we saw a request for a home visit was received from a nursing home via fax but had not been passed to the GP until the end of the day. Whilst the patient was seen, staff were reminded to keep the fax machine stocked with paper and the nursing home was contacted to request that they do not ask for home visits via fax.

National patient safety alerts were received and disseminated to relevant staff by the practice manager. Staff we spoke with were able to show us examples of recent alerts they had received relevant to their roles and responsibilities. However, there was no system to follow up alerts to ensure they had been acted upon including those relating to medicine safety. The practice manager told us about action they had taken in response to information received on the Ebola virus. There was not however any clear evidence that safety alerts relevant to the practice were routinely discussed among staff to identify and ensure action needed was taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We reviewed training records for four members of staff. These showed that the staff had received relevant role specific training on safeguarding. Staff that we spoke with were aware how to recognise signs of abuse in older people, vulnerable adults and children. We saw that there was a safeguarding policy in place and staff were aware of this policy which included flow charts of referral processes. Contact details for making a safeguarding referrals were also easily accessible to staff.

The practice had a dedicated GP appointed as the practice safeguarding lead. They had been trained to a level 3 (the required level for GPs) for safeguarding children. All the staff we spoke with were aware who the lead was and told us that they would speak with them or another member of the clinical staff if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This ensured staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. A search of the patient record system identified children that had been identified as at risk. The lead GP for safeguarding was unavailable to speak with us on the day of our inspection. However, staff told us that informal meetings were held with the health visitor in which any concerns about children at the practice were discussed.

Requires improvement

Are services safe?

A chaperone policy was in place and notices alerting patients to this were displayed. The practice nurse usually acted as the chaperone. However, reception staff spoken with also told us that they occasionally acted as chaperones. None of the staff had received chaperone training and did not demonstrate an understanding of their role and duties when acting as a chaperone such as where to stand to be able to observe the examination.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic record system (EMIS) which collated all communications about the patient including scanned copies of communications from hospitals. The practice had not undertaken any recent audits as to the completeness of records held.

Medicines management

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 medicines were kept at the required temperatures. This was usually carried out on a daily basis by the practice nurse or in their absence one of the administrative staff. Over the last two months records of the refrigerator temperature in the nurse's room had been completed on most days. However, records for the refrigerator in the midwives' room were only available from 9 October 2014, less than two weeks previously. Staff advised us that checks had been made but believed the records had been lost.

All the medicines and vaccines we checked were within their expiry dates. However, no records were available to demonstrate that the practice regularly checked emergency medicines were within their expiry date and suitable for use.

Vaccines were administered by the practice nurse. We saw evidence from training records that the practice nurse had recently received training in the administration of childhood immunisations and seasonal flu vaccinations.

There were clear processes for the management of repeat prescriptions. Prescriptions were reviewed and signed by the GP before they were given to the patient. We saw from the minutes of practice meetings that staff had received training from the practice pharmacist in managing repeat prescriptions. Administrative staff who generated prescriptions told us how they checked requests for repeat prescriptions for medicine review dates so that patients could be alerted. Staff also told us that prescription pads were securely locked away at night to minimise the risk of theft to unlawfully obtain medicines.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results of this monitoring. We reviewed medicine reviews carried out for two patients on high risk medicines which confirmed that the procedure was being followed. The GP told us that they were supported by the practice pharmacists in relation to medicines management at the practice who would undertake complex medicine reviews.

We spoke with the GP about prescribing reviews that had been undertaken. These are undertaken to reduce unnecessary prescribing of medicines such as those likely to have little impact on patient outcomes. The GP told us that they had reduced their antibiotic prescribing but was unable to provide any data on this.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy with good flooring and work surfaces which could be easily cleaned. Cleaning of the floors and toilet areas were carried out by an external cleaning provider. All remaining cleaning was carried out in-house. We saw cleaning schedules in place for the in-house cleaning which was carried out by the practice manager. Comments received from patients told us that they found the practice clean and had no concerns about cleanliness or infection control.

The practice had an infection control lead who had undertaken training in infection control during the last 12 months. This was currently the practice nurse although we were advised that there were plans to train one of the receptionists to undertake this role. The practice had recently undertaken an infection control audit (during the month of our inspection); this did not raise any major concerns. An action plan had been produced. However, we noticed a number of issues that had not been picked up through the audit; for example, the lid to the bin for clinical waste in the midwives' room was missing and records of staff immunisation or appropriate risk assessments were incomplete.

There were various infection control related policies and procedures in place for staff to refer to in order to plan and

implement control of infection measures. For example, we saw that staff had access to personal protective equipment. The practice had also implemented their needle stick injuries policy following an incident involving a member of staff.

Hand hygiene techniques signage was displayed in the clinical areas. We saw hand washing sinks with hand soap and hand towel dispensers in the treatment rooms we visited.

We saw that testing for legionella (a bacterium found in the environment which can contaminate water systems in buildings) had taken place. This was arranged externally by the owners of the health centre.

Equipment

Staff had access to the equipment they needed to enable them to carry out diagnostic examinations, assessments and treatments. However, we found systems for ensuring equipment was regularly checked to ensure they were safe and fit for use was not robust. We saw evidence that some equipment had been tested for electrical safety and maintained regularly including calibration. Equipment tested displayed stickers indicating the last testing date. However, there was no inventory of equipment held at the practice which required maintenance or testing for electrical safety. We noticed that some equipment had been missed, for example calibration of a refrigerator in the clinical room and portable appliance testing of computer equipment. The practice manager advised us that she had believed the computers were checked by the local Clinical Commissioning Group (CCG). Evidence was sent following the inspection that the computers had undergone portable appliance testing.

Instruction manuals were available for equipment in use so that staff were able to refer to them where necessary.

Staffing and recruitment

The practice had a low turnover of staff. Staff told us that there had not been any new members of staff recruited in the last five years. We looked at a sample of staff files but these did not contain information to demonstrate appropriate recruitment processes and checks had taken place to ensure staff were of good character and had the necessary skills and experience. We saw that the practice had a recruitment policy which detailed the process and checks needed. This had been put in place since the last member of staff was recruited and provided a more robust process if used.

Criminal checks via the Disclosure and Barring Service (DBS) had been undertaken for the practice nurse (who aside from the GP partners was the only employed clinical member of staff). The practice manager told us that DBS checks had not been undertaken for reception staff due to the low risk to patients. However the roles and responsibilities of the administrative staff had not been formally risk assessed to demonstrate why these checks were not needed.

The practice used a locum on regular basis for two sessions each week. Documents were made available in relation to this locum such as membership of their professional body, professional indemnity and DBS checks. We also saw evidence available in the practice nurses file of their registration with their professional body.

The practice manager told us about the arrangements in place for managing expected and unexpected absences. Administrative staff would have staggered starting times to ensure cover throughout the day. Only one member of staff would be allowed leave at any one time and if an emergency arose other members of staff would be asked to provide cover.

There were no clear arrangements in place for managing unexpected absences with clinical staff. The GP we spoke with told us that locum cover would only be provided in their absence for long term sickness. Appointments for patients that could not be seen by their GP partner would have to be cancelled. There were also no arrangements in place if the practice nurse was unexpectedly absent.

Monitoring safety and responding to risk

The building in which the practice operated was not directly owned by the practice. Maintenance of the building and environment was carried out by the owners as part of the contract. We found the practice premises to be well maintained.

The practice had undertaken a number of risk assessments in relation to issues that may impact on the running of the practice and business continuity. Each risk had been rated and mitigating actions recorded to reduce and manage the risk. However the practice did not undertake any routine

checks of the environment in order to identify any issues that may need to be addressed or assure itself that any maintenance required had been completed. We saw little evidence of discussions with the owners of the premises to discuss maintenance issues.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage medical emergencies. We saw records showing that staff had recently attended training in basic life support and were awaiting their certificates to arrive. Emergency medicines and equipment were available including access to oxygen in a secure but accessible location. All staff asked knew the location of the emergency medicines and equipment but told us they had not had any cause to use them. We found the medicines and oxygen were in date. Records made available to us showed that the oxygen was regularly checked but no records were available for the emergency medicines.

Emergency medicines were available for the treatment of chest pain, asthma and anaphylaxis. The practice did not routinely hold stocks of medicines for treatment of suspected meningitis or hypoglycaemia. There were no risk assessments in place to identify why these emergency medicines were not required and arrangements in place to manage situations in which they might be required.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as power failure and access to the building. Staff told us that they had not needed to implement the plan.

The practice was not able to show us any formal fire risk assessment of the practice or had assurance that this had been carried out by the owners of the building. The practice manager had undertaken fire training prior to our inspection and had identified precautions that needed to be undertaken to minimise the risk of fire .

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP we spoke with was familiar with best practice guidance received from the National institute for Health and Care Excellence (NICE) and from local commissioners. We saw that the practice manager disseminated information received to relevant staff. The practice nurse retained a folder for reference with best practice guidance and was able to give specific examples of how they implemented it. However, there were no formal arrangements where the implications of new guidance for patients were discussed with relevant staff and actions for implementation agreed.

Both the GPs and practice nurse participated in reviews of patients with long term conditions. The practice nurse told us that they felt supported by the GPs if they needed any advice. They told us that they had informal clinical meetings with the GPs. Our GP specialist advisor reviewed case notes for two patients with high blood pressure which showed they were on appropriate treatment and received regular reviews.

The GP we spoke with told us that they had made improvements in antibiotic prescribing. However, data from the CCG for August 2014 still showed the practice as a high prescriber compared to other practices in the local CCG group.

We were unable to determine how the practice compared nationally with referral rates to secondary and other community care services. Both the practice manager and GP were unable to retrieve this information about their referral rates from their IT system. The practice did not undertake regular reviews of its elective and urgent referrals to identify any areas for improvement.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision making.

Management, monitoring and improving outcomes for people

The GP showed us two clinical audits that had been carried out in the last 15 months. These included a rolling audit relating to diabetes care which had demonstrated improvements in the review of diabetic patients. The second related to the availability of appointments versus demand for the service. Although this audit had been re-audited in January 2014 there had been no analysis of the results to demonstrate whether there had been any improvements. The GP also told us about a medicines audit that had been carried out by the CCG pharmacist which showed improved prescribing practice of the medicines audited.

The practice was not able to show us how it performed in comparison with other practices. There was no evidence that benchmarking data was routinely discussed and used to improve performance at the practice. Both the practice manager and the GP had difficulty interrogating their IT system and providing us with information about their performance. We were given an overall summary of their QOF points for 2013/14 which showed maximum points were achieved in some areas such as heart failure but fell short in areas such as diabetes, COPD and asthma.

Data we held about the practice showed that their scores were lower than average compared with other practices nationally for two indicators relating to diabetes, the ratio of reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD) and regular multi-disciplinary case review meetings for patients on the palliative care register.

Staff told us that they followed up patients who were due for a review of their health condition and medicine review. We saw five examples of medicine reviews that had been undertaken for patients with depression and hypertension which confirmed this.

Effective staffing

Practice staffing consisted of two GPs, a practice nurse, practice manager and administrative staff. We reviewed staff training records and saw that staff were up to date with attending the practice's mandatory courses such as annual basic life support. Both GPs were up to date with their yearly continuing professional development requirements and had dates for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

Requires improvement

Are services effective?

(for example, treatment is effective)

All staff undertook appraisals; these were usually carried out annually although not all staff had received one in the last 12 months. We saw from the appraisals that training and any future learning needs had been discussed. Staff interviews confirmed that the practice was supportive in providing training. Training records confirmed that staff had received relevant training to their role in the last 12 months. For example administrative staff had received corporate update training at the local hospital which covered areas such as infection control, information governance and confidentiality and some e-learning modules that were available for staff to complete.

The practice nurse had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on the administration of vaccines and updates in the management of long term conditions such as chronic pulmonary disease and diabetes. The practice nurse told us that they had received training in cervical cytology but were unable to find their certificate during our inspection.

Working with colleagues and other services

Information received about patients such as results from medical tests, letters from hospitals and out of hours providers were received both electronically and by letter. Letters were reviewed by the GP who would allocate any tasks or action needed to the reception staff. The practice did not use the electronic tasking available to record action in response to information received and letters were scanned onto the patient record after being seen by the GP. Although we saw no evidence of actions being missed there was no robust audit trail to ensure this was the case.

The practice had chosen not to participate in the new enhanced service to follow up patients discharged from hospital but may in the future. An enhanced service is a service that is provided above the standard general medical service contract.

The GP we spoke with told us that their GP partner would meet with other health professionals such as the district nurse and health visitor (based in the same building) to discuss patient needs including those on the risk register. The practice did not hold any formal multi-disciplinary meetings to discuss the needs of complex patients for example those with end of life care needs to ensure important information was shared.

Information sharing

Staff told us that they used Choose and Book system to make referrals. The Choose and Book system enables patients to choose which hospital they would like to be seen in and to book their own outpatient appointment in discussion with their chosen hospital. The practice was unable to identify how many of its referrals had been made using this system. We also spoke to the GP about how they shared relevant information with the out of hours provider for patients who may need to access the out of hours service. The practice was unable to demonstrate that they did this.

The practice had signed up to the electronic Summary Care Record. The practice manager showed us the system in place. Summary Care Records provide healthcare staff treating patients in an emergency or out of hours with faster access to key clinical information.

The practice had systems in place to provide staff with the information they needed. An electronic patient record (EMIS Web) was used by staff to co-ordinate, document and manage patient's care. The system had been in place for approximately 18 months. Administrative staff were positive about the EMIS system and the ability to scan information on to the system.

Consent to care and treatment

Staff we spoke with did not demonstrate a clear understanding of the Mental Capacity Act and their duties in fulfilling it and had not received any training in this area. The Mental Capacity Act 2005 is the legislation that governs decision making on behalf of adults and applies when people do not have the mental capacity at that point in their lives for specific decisions. The practice was unable to provide any specific examples as to how decisions where capacity may be an issue were made. However they were able to show us screening tools that they used to identify mental health problems and dementia. This enabled them to identify patients who needed referral to specialist care.

The practice was also unable to detail how it would apply the Gillick competency for assessing whether children under 16 were mature enough to make decisions without parental consent. The GP we spoke with told us that children usually came with their parents and had no current examples where they had needed to apply the Gillick competency.

The practice did not undertake minor surgery for which formal consent would be required. However, the practice

Requires improvement

Are services effective?

(for example, treatment is effective)

nurse told us of a situation in which a patient who had come in for a procedure had wanted more time to think about it. The patient had been given information to enable them to make a decision whether to go ahead with the procedure.

Health promotion and prevention

All new patients registering with the practice were invited to attend a health check with the practice nurse. If there were any concerns arising from the health check the practice nurse told us that they would ask the GP to see the patient straight away or arrange an appointment with the GP.

At the time of our inspection the practice offered health checks to patients over 75 years and was preparing to start offering NHS Health checks for patients aged 40 to 74 years within the next few weeks. The GPs and practice nurse had recently undertaken training to do these health checks and posters had been displayed to advertise the service.

The practice had identified via a patient register patients who may require additional support such as patients with learning difficulties. Seven patients had been identified on this register however only one patient had received an annual review within the last 12 months. This did not provide assurance that information was effectively being used to target patients in vulnerable groups.

The practice offered some health promotion and prevention services. These included cervical screening, flu vaccinations and childhood immunisations. There was some health promotion information displayed within the practice including a notice to encourage Asian patients over 40 years (who may be more susceptible to diabetes) to make an appointment to have a blood test.

At the time of the inspection the practice had a 74% uptake of cervical smear tests of eligible patients. The practice was unable to show how this figure compared with other practices in the CCG but told us they sometimes found it difficult to encourage Asian women to attend. The practice told us that the CCG were following up patients who did not attend for their cervical smear test by letter and that they would send a final reminder for those who had still not attended. Information we had available on childhood immunisations from April 2013 showed uptake of childhood vaccinations at the practice was slightly lower than the CCG average.

The practice told us that they had smoking status recorded for 95% of its population but was unable to provide any information relating to referrals to smoking cessation services. The practice manager told us that the practice had offered a smoking cessation service but had stopped due to lack of uptake. The practice was also unable to provide information as to the percentage of patients in the working age group who had received a blood pressure check.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 39 patients undertaken with involvement from the practice's Patient Participation Group. The evidence from all these sources showed that patient satisfaction with how they were treated and whether it was with compassion, dignity and respect was variable.

The national patient survey showed the practice was below the national average at 74.4% for patients rating the practice as fairly good, good or very good. The practice's own in house patient survey which was carried out in February 2014 found 79% of patients who responded to the survey said they would recommend the practice to others. The survey did not go into any more detail than this about the patient experience. There had been four reviews left on the NHS Choices website in the last 12 months. Three of these were positive about the service and one was negative.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients described staff as helpful and that they were happy with the service they received. We received comments from seven patients who, although were satisfied with the practice, raised issues such as confidentiality in the reception area, access to appointments and dissatisfaction with their consultation. There were however no overall themes arising from the issues which were raised in the comment cards.

We saw that consultations were carried out in the privacy of the consulting rooms. We spoke with five patients. All told us that they were treated with dignity and respect. One patient told us that they had discussed at a Patient Participation Group (PPG) the issue of staff knocking and walking straight into a consulting room and now staff would wait after knocking. We saw notices on doors to remind staff of this. Disposable curtains were provided in consulting rooms and treatment rooms so that the patient's 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 heard. However information at the reception desk could be overheard. Reception staff were aware of this and told us they would offer somewhere more private if patients wanted to speak in confidence.

None of the patients we spoke with or feedback received indicated that they had any concerns about patient confidentiality. Staff demonstrated an awareness of protecting patient confidentiality and we saw that staff had signed confidentiality agreements as part of their staff contract.

Staff told us that us that they had not encountered any incidents of discriminatory behaviour and that the practice manager installed the ethos of respect and dignity at the reception staff meetings. We saw that a complaint about staff attitude had been appropriately dealt with by the practice. We saw positive, polite and helpful interactions between staff and patients during our visit.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey we reviewed showed that patients felt mostly involved in planning and making decisions about their care and treatment. Data available from this survey showed the practice to be below the national average for respondents that said the GP involved them in care decisions and who felt the GP was good at explaining treatment and results.

Patients we spoke with as part of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Patient feedback from comment cards received reiterated these views. Patients also told us they felt listened to and that information was explained to them in a way they could understand to help them make decisions about their own health care.

The practice manager told us that approximately 30% of the practice population did not speak English as their first language. Translation services were available for patients where language was a barrier to accessing the service. Staff also told us how one of the GP partners could speak several languages. However, we did not see any information alerting patients of the availability of translation services or much information displayed in a language other than English.

Requires improvement

Are services caring?

We spoke with the GP about end of life care planning at the practice and patient involvement in agreeing these. The GP was unable to provide any examples of end of life care plans or joint working with palliative care nurses and explained that there was a resistance to end of life planning from some ethnic groups in the practice population.

Patient/carer support to cope emotionally with care and treatment

Feedback we received from patients in person and through the CQC comment cards indicated that staff were generally supportive of their needs. Data from the national patients survey showed 76% of patients felt the GP was good or very good at treating them with concern. This was below the national average. Results for the nurse were more in line with the national average.

The practice had a range of health information available in the practice. The practice website also had links to various health conditions so patients could find out more about them. We saw leaflets which signposted patients to local carer support services. The practice also had notices asking patients to inform them if they were a carer so that they could be supported.

The practice was unable to provide any details about specific arrangements in place for supporting patients who had recently suffered bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with the local Clinical Commissioning Group (CCG) where the locality improvement plan was discussed. We saw from the minutes of the meetings that a GP from the practice attended these meetings which helped to keep them informed about local priorities and progress on service developments.

There had been very little turnover of staff during the last five years which enabled good continuity of care. Results available from the national patient survey showed that patients were usually able to get an appointment with their GP of choice. Staff told us that longer appointments were available for patients who needed them such as those with learning disabilities. Young children and elderly patients would always be seen and home visits were carried out for patients who were unable to attend the surgery.

The practice told us that it met with other agencies such as health visitors to share information. However, the practice could not demonstrate that it participated in any formal multi-disciplinary meetings to discuss the care and support needs of patients and their families. For example the practice had not implemented the gold standards framework for end of life care. The practice was also unable to provide examples as to how it regularly shared information (using patient notes) with relevant agencies about specific patient needs.

Tackling inequity and promoting equality

The practice was able to demonstrate some understanding of the needs of its population and help them to access the help and support they needed. For example, staff were aware that the practice covered a diverse community. The practice nurse was able to show us information she gave to support diabetic patients during Ramadan when they were fasting. Staff had access to translation services and the some staff were able to speak more than one language.

The practice was located in a purpose built health centre on the ground floor with disabled parking and toilet facilities. There was a low reception desk which made it easier for patients who used a wheelchair to speak with the reception staff.

The practice was not able to provide any specific examples as to how it planned services and supported the needs of vulnerable groups such as those with a learning disability, no fixed abode or the unemployed. The practice had a register for patients with learning disabilities but this showed only one patient out of the seven on the register had been reviewed in the previous 12 months. Staff told us that they did not have any patients with no fixed abode and gave conflicting information as to how they would register them as a new patient which required an address and health assessment to register.

Access to the service

Appointments were available from 9.00am and 6.30pm on Monday, Tuesday, Thursday and Friday and between 9.00am and 1pm on Wednesday. Extended opening hours were available Monday and Thursday evenings between 6.30pm and 7.10pm which would benefit patients with work commitments. Staff told us that appointments could be booked three to four weeks in advance and urgent appointments were available daily. Telephone consultations were also available for patients where appropriate. At the time of our inspection the practice did not offer online booking for appointments.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. There were arrangements in place to ensure patients received urgent medical assistance when the surgery was closed. Information on the out-of-hours service was provided to patients in the practice leaflet and on the practice answerphone.

Feedback from patients through the national patient survey and comments received from patients as part of our inspection indicated that patients were generally satisfied with the appointment system. Patients told us that they were able to make an appointment easily and if needed could get urgent appointments the same day if needed.

The practice was situated on the ground floor of a shared health centre; this allowed for easier access for patients with mobility difficulties and pushchairs.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints at the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. A complaints and comments leaflet was available in the waiting room to help patients understand the complaints policy. This set out the process for patients to follow including where to go if they were not satisfied with the response received from the practice. None of the patients we spoke with during our inspection had ever made a complaint about the practice or felt they had needed to.

Prior to our inspection the practice sent us a summary of the complaints they had received in the last 12 months. There were three in total and information provided indicated that the complaint had been appropriately dealt with and in a timely way. We saw evidence from practice meetings where complaints had been discussed with staff to ensure any lessons learnt were acted upon on an individual basis. The practice did not make it clear whether complaints received were formal letters or verbal complaints as we saw no original letters available. It was also not clear whether responses were made verbally or via letters as only one letter of response was available in the complaints file. This information would provide a clearer audit trail as to the management of the complaint.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice did not have a clear vision as to what it wished to achieve and there were no formal documented plans in place.

Reception staff told us and we saw from the minutes of practice meetings that treating patient with respect and dignity were important to the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. Hard copies were available in the practice manager's office. The practice nurse also kept their own file of policies that were relevant to them. We looked at some of the policies available and saw that they were up to date but had not always been adapted to ensure they were specific to the practice. The practice did not collect evidence to confirm that staff had read and understood relevant policies that had been put in place.

Monthly practice meetings were held with all staff. We looked at the minutes from meetings held between June and October 2014. These primarily focussed on training and dissemination of information to practice staff. They did not specifically cover issues relating to performance, quality and risk. The practice manager told us that there were also clinical meetings held but they were not formally documented and they did not personally attend these meetings.

We did not see any evidence to show how the practice used the Quality and Outcomes Framework (QOF) to improve performance or any evidence of local peer review with other practices. The practice staff had difficulty in producing information relating to their performance against QOF for us. There was no evidence that QOF data was being discussed or action plans to improve outcomes against QOF targets were being developed and implemented. The practice provided us with a summary of points they had achieved through QOF during the last financial year 2013/14. This showed the practice had achieved maximum points for the management of some conditions such as heart failure, chronic kidney disease and cancer but there were still some areas which fell short of maximum points which included diabetes, asthma and chronic obstructive pulmonary disease.

There was evidence of clinical audits; however these were not always completed to ensure a full audit cycle. This is where a second audit is undertaken to demonstrate whether improvements to services have been achieved. The practice had undertaken risk assessments to address potential risks relating to the operation of the service and business continuity. However there were no specific arrangements for the recording, identification and discussion of new risks for example those identified through audits to ensure any actions identified were implemented.

Leadership, openness and transparency

Staff told us that they felt able to raise issues with the practice manager and we saw evidence where poor performance in response to a complaint had been appropriately addressed and managed.

We did not see evidence of a clear leadership structure at the practice. Staff told us they were clear about their own roles and there was some evidence of lead roles. For example one partner was the lead for safeguarding. The practice nurse was the current infection control lead although there were plans for this role to pass to one of the reception staff once they were trained.

We saw that staff had practice meetings but this did not specifically relate to performance and we saw no evidence from meetings held that performance issues were discussed in order to drive improvement. The practice manager did not appear to have much involvement in the performance management of the practice. During our visit we found the staff struggling to provide performance information or use the IT systems in place to produce the information requested.

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from patients through an in-house patient survey carried out in February 2014. The survey focused on three priority areas: patient views on online booking; satisfaction with opening hours and whether patients would recommend the practice to others. Results from the survey showed that 63% of respondents

Are services well-led?

Requires improvement

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

wanted online booking. The practice manager advised us that they were in the process of putting this in place. Staff also told us that extended hours had been introduced in response to the 18% of patients who said they were not happy with the opening hours. There had also been a focus on reminding patients to cancel their appointment if it was no longer needed so that it could be offered to someone else.

The practice had a patient participation group (PPG) but the number of members had declined and at the last meeting in March 2014 only one member had attended. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. The PPG meetings had been put on hold while the practice advertised for new members. The practice had advertised for new members on the practice website and in the practice leaflet however, there had been little progress made with this. We spoke with a member of the PPG, they told us that when the PPG had been running that they had felt listened to and told us about changes such as how the new phone system had made it easier for patients to get through to the practice.

The practice held regular staff meetings which provided opportunities for staff to raise any issues with colleagues and management. Members of staff we spoke with during our inspection told us that they felt supported and that senior staff were approachable if they needed to raise any issues with them. Staff also told us that they felt involved in discussions to improve the service.

Not all staff we spoke with could tell us if there was a whistle blowing policy. Whistleblowing is the means by which staff can raise concerns about poor practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development. The practice nurse told us that they received supervision and support from one of the GP partners and through the CCG nurse facilitator. They also attended nurses forums. We saw that reception staff had access to regular training to update their knowledge. We saw that most some staff had received an appraisal in the last 12 months but not all. Where appraisals had taken place staff training and development was discussed.

The practice shared learning from significant events on an individual basis and via staff meetings. For example where information had been incorrectly scanned to the wrong patient records.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from them carrying on of the regulated activity. The practice did not have effective systems to: · Monitor the quality of care patients received. · Monitor safety of the environment including arrangements for fire safety. · Ensure only suitable staff are employed through appropriate recruitment checks and for risk assessing the need for DBS checks in relation to staff roles and responsibilities. · Manage staffing during expected and unexpected absences · Maintain equipment. · Monitor emergency medicines to ensure they are present and fit for use when required. Regulation 10 (1)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person must have suitable arrangements in place in order to ensure that persons employed for the

This section is primarily information for the provider

Compliance actions

purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard.

Staff undertaking chaperoning duties did not have a good understanding of their duties so that they can provide appropriate support to patients.

Regulation 23 (1)(a)