Plumbridge Medical Centre

Quality Report

32-33 Plumbridge Street
London
SE10 8PA
Tel: 0208 692 7591
Website: www.plumbridgemedicalcentre.nhs.uk

Date of inspection visit: 27 September 2017
Date of publication: 21/11/2017

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?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Plumbridge Medical Centre on 27 January 2016. The overall rating for the practice was good. The full report of this inspection can be found by selecting the 'all reports' link for Plumbridge Medical Centre on our website at www.cqc.org.uk.

On 27 September 2017 a second announced comprehensive inspection was carried out 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 was still meeting the legal requirements of the regulations. Overall the practice is now rated as requires improvement.

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

- Staff understood their responsibilities to raise concerns and to report incidents and near misses. However, not all staff were aware of the correct documentation to use for reporting incidents.
- Risks to patients were not always well managed, such as those relating to recruitment checks; infection control; fire drills; monitoring of emergency equipment and medicines and the management of patient safety alerts.
- Staff had not received an appraisal in the preceding 12 months.
- Not all staff acting as chaperones had been trained for the role or received a Disclosure and Barring Service (DBS) check.
- Patient Group Directions were out of date and had not been signed by the current practice nurse.
- The cold chain policy was not adequate and there was insufficient monitoring of the cold chain procedures within the practice.
- We saw no evidence that clinical audits were driving improvements to patient outcomes.

Summary of findings

- The practice had a number of policies and procedures to govern activity but not all included a review date.
- Not all staff had received training in infection control, fire safety, safeguarding and information governance relevant to their role.
- The practice had identified only six patients as carers (0.2% of the practice list).
- Patients we spoke with said they found it easy to make an appointment with a GP and were treated with compassion, dignity and respect.
- National GP Patient survey satisfaction rates were above or comparable to local and national averages for all indicators.
- Quality performance data showed patient outcomes were comparable to the local and national averages.

The provider must ensure care and treatment are provided in a safe way for service users. There were areas where the provider must make improvements:

- The provider must ensure there is a safe and effective cold chain procedure in place and monitor that this is followed by all staff.
- The provider must ensure that a process is in place to ensure results are received for all cervical screening samples sent for testing.
- The provider must ensure that all necessary employment checks are carried out for all staff.
- The provider must ensure that a programme of annual appraisals for all staff is implemented.
- The provider must ensure that patient group directions are in date and signed by all relevant personnel.
- The provider must ensure that all staff undertaking chaperone duties are trained for the role and have received a Disclosure and Barring Service (DBS) check.
- The provider must ensure that there is an appropriate procedure in place following the receipt of patient safety alerts, such as those produced by the Medicines and Healthcare products Regulatory Agency (MHRA).
- The provider must provide staff with the opportunity to undertake training appropriate to their role.

There were also areas where the provider should make improvements:

- The provider should develop and implement an appropriate clinical audit programme to identify and implement necessary improvements to patient care.
- The provider should implement an effective process for regular checking of emergency equipment and medicines.
- The provider should develop strategies to encourage patients to join the patient participation group (PPG) and establish regular communication with group members.
- The provider should continue to work towards increasing the immunisation uptake rates for all standard childhood immunisations.
- The provider should continue to actively encourage patients to participate in national screening programmes.
- The provider should review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to all carers registered with the practice.
- The provider should carry out regular staff meetings.
- The provider should carry out regular infection control audits and fire drills.

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 and improvements must be made.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, not all staff were aware of the correct documentation to use.
- An infection control audit had not been undertaken in the previous 12 months and not all staff had received infection control training relevant to their role.
- Fire drills had not been undertaken since 2015.
- Staff we spoke to demonstrated that they understood their responsibilities regarding the safeguarding of children and vulnerable adults but some administration staff had not received training relevant to their role. This was however being addressed by the provider.
- There was no system in place to regularly monitor that emergency equipment and medicines were in working order and in date.
- Records were not kept of action taken as a result of patient safety alerts, such as those produced by the MHRA and records were not kept to confirm that the information was passed to other clinical staff where appropriate.
- All administrative staff acted as chaperones, however, not all staff had been trained for the role or received a Disclosure and Barring Service (DBS) check.
- Patient Group Directions had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation. However, these were out of date and had not been signed by the current practice nurse.
- The cold chain policy was not adequate and there was insufficient monitoring of the cold chain procedures within the practice.
- Appropriate checks had not been undertaken prior to employment. For example, proof of identification; evidence of satisfactory conduct in previous employment and checks through the DBS.

Summary of findings

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services as there are areas where improvements should be made.

- Data from the Quality and Outcomes Framework showed patient outcomes were comparable with the local and national averages.
- Staff were aware of current evidence based guidance.
- There was limited evidence that clinical audit was informing quality improvement within the practice.
- There was no system in place to ensure results were received for all samples sent for the cervical screening programme.
- Clinical staff had the skills and knowledge to deliver effective care and treatment. However, some of the administrative staff had not completed training in information governance, fire safety, infection control or safeguarding. The provider was aware of the need to ensure this was addressed and had therefore recently purchased access to an on-line training programme for staff.
- Staff had not received an appraisal or had the opportunity to complete a personal development plan in the 12 months prior to the inspection.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- The practice had identified only six patients on the patient record system as carers (0.2% of the practice list). Staff told us that there were patients who were known to the GPs as carers but their carer status had not been recorded on the patient record system.
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients felt they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was limited information available to help patients understand the complaints system and appropriate improvements were not always identified from patient complaints.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led as there are areas where improvements should be made.

- The practice had a vision to deliver high quality care and promote good outcomes for patients. Staff were aware of the vision and their responsibilities in relation to it. However, the overarching governance framework was not sufficiently comprehensive to support the delivery of the strategy.
- There was a clear leadership structure and staff felt supported by the Practice Manager.
- The practice had policies and procedures to govern activity but these did not all include a review date.
- Staff had not received annual performance reviews or appropriate training opportunities.
- Practice meetings attended by all staff had not taken place since July 2016.
- We were told that issues raised as a result of complaints from patients were discussed with staff and appropriate action taken. However, from the complaints we reviewed we found that appropriate improvements were not always identified and the practice did not maintain appropriate records to ensure lessons were shared with all staff.
- The provider did not have an appropriate clinical audit programme in place to identify and implement necessary improvements to patient care.
- The practice did not have an active patient participation group.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider is rated as requires improvement for providing safe, effective and well-led services. The issues identified as requiring improvement overall affected all patients including this population group.

- Nationally reported data showed that outcomes for patients with conditions commonly found in older people were comparable to local and national averages.
- Staff were aware of how to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Older patients were provided with health promotion advice and support to help them to maintain their health and independence for as long as possible

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The provider is rated as requires improvement for providing safe, effective and well-led services. The issues identified as requiring improvement overall affected all patients including this population group.

- The lead GP and practice nurse had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Nationally reported data showed that outcomes for patients with long-term conditions were comparable to local and national averages.
- The practice followed up patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.

Summary of findings

- Patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The provider is rated as requires improvement for providing safe, effective and well-led services. The issues identified as requiring improvement overall affected all patients including this population group.

- We found there were systems in place to identify and follow up children who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates for 2015/16 were below the national target for standard childhood immunisations. The practice was aware of the need to improve uptake rates and were liaising with health visitors to address this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal and post-natal care and child health surveillance clinics.
- The practice offered urgent appointments for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider is rated as requires improvement for providing safe, effective and well-led services. The issues identified as requiring improvement overall affected all patients including this population group.

- The age profile of patients at the practice was mainly those of working age and the practice had adjusted the services it

Summary of findings

offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours appointments were available until 7.30pm on a Monday evening and appointments were available daily until 6pm.
- The practice offered online services such as ordering repeat prescriptions; making and cancelling appointments and updating contact details.
- A full range of health promotion and screening was available that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider is rated as requires improvement for providing safe, effective and well-led services. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those patients whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients who required them.
- The practice worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff we interviewed knew how to recognise signs of abuse and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider is rated as requires improvement for providing safe, effective and well-led services. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice carried out advance care planning for patients living with dementia.

Summary of findings

- Performance data for 2015/16 showed that 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was above the local average of 86% and national average of 84%. The exception reporting rate for this indicator was below the local and national average.
- The practice reviewed annually the physical health needs of patients with poor mental health and dementia.
- The practice monitored repeat prescribing for patients receiving medicines for mental health needs.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an annual assessment.
- For patients experiencing poor mental health the practice had information available about how they could access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2017 showed that patient satisfaction for the practice was above or in line with local and national averages. 375 survey forms were distributed and 63 were returned. This represented a response rate of 17% (3% of the registered patient list).

- 94% of patients described the overall experience of this GP practice as good compared with the CCG average of 81% and the national average of 85%.
- 90% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 74% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 35 comment cards which were all positive about the standard of care received. Comments included reference to the ease in getting appointments, the cleanliness of the premises and the helpfulness of staff.

We spoke with eight patients during the inspection. Patients said they were satisfied with the care they received and thought staff were approachable and helpful.

Results of the monthly Friends and Family survey were reviewed regularly by the provider. Recent survey results showed that the majority of patients would recommend the practice to friends and family:

- July 2017 (196 patients surveyed – 32 responses) – 72% of patients were likely to recommend the practice.
- August 2017 (195 patients surveyed – 14 responses) – 86% of patients were likely to recommend the practice.
- September 2017 (190 patients surveyed – 22 responses) – 77% of patients were likely to recommend the practice.

Areas for improvement

Action the service MUST take to improve

- The provider must ensure there is a safe and effective cold chain procedure in place and monitor that this is followed by all staff.
- The provider must ensure that a process is in place to ensure results are received for all cervical screening samples sent for testing.
- The provider must ensure that all necessary employment checks are carried out for all staff.
- The provider must ensure that a programme of annual appraisals for all staff is implemented.
- The provider must ensure that patient group directions are in date and signed by all relevant personnel.
- The provider must ensure that all staff undertaking chaperone duties are trained for the role and have received a Disclosure and Barring Service (DBS) check.
- The provider must ensure that there is an appropriate procedure in place following the receipt of patient safety alerts, such as those produced by the Medicines and Healthcare products Regulatory Agency (MHRA).
- The provider must provide staff with the opportunity to undertake training appropriate to their role.

Action the service SHOULD take to improve

- The provider should develop and implement an appropriate clinical audit programme to identify and implement necessary improvements to patient care.
- The provider should implement an effective process for regular checking of emergency equipment and medicines.
- The provider should develop strategies to encourage patients to join the patient participation group (PPG) and establish regular communication with group members.

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- The provider should continue to work towards increasing the immunisation uptake rates for all standard childhood immunisations.
- The provider should continue to actively encourage patients to participate in national screening programmes.
- The provider should review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to all carers registered with the practice.
- The provider should carry out regular staff meetings.
- The provider should carry out regular infection control audits and fire drills.

Plumbridge Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector**.** The team included a GP Specialist Adviser and an Expert by Experience.

Background to Plumbridge Medical Centre

Plumbridge Medical Centre is situated in purpose-built accommodation in a mainly residential area of Greenwich, London, in the Royal Borough of Greenwich. Greenwich Clinical Commissioning Group (CCG) is responsible for commissioning health services for the locality.

The practice has 2284 registered patients. The practice age distribution differs from the national average in that they have a larger than average male patient population aged 25 to 50 years and a lower than average population over 65 years.

The provider is registered with the CQC as an individual. Services are provided from one location at 32 Plumbridge Street, Greenwich SE10 8PA. Services are delivered under a General Medical Services (GMS) contract. The practice is registered with the CQC to provide the regulated activities of maternity and midwifery services; treatment of disease, disorder and injury and diagnostic and screening procedures.

Clinical services are provided by the full-time lead GP (female); a salaried GP (male) providing two sessions per week, a locum GP (female) providing one session per week and a practice nurse providing one morning and one afternoon session per week.

Administrative services are provided by a Practice Manager (35 hours per week) and six part-time reception staff (54.5 hours per week).

The surgery reception is open between 8am and 6.30pm Monday to Friday. With extended hours provided on Monday until 7.30pm.

Appointments are available with a GP daily between 9.20am and midday and 4pm to 6pm. Extended hours appointments are available until 7.30pm on Monday.

Appointments are available with the Practice Nurse between 2pm and 6pm on Tuesday and between 10am and 2pm on Friday.

When the surgery is closed the out of hours GP services are available via NHS 111.

Patients also have access to GP services out of hours at the two GP Access Hubs which are open on Saturday from 9am to 5pm; Sunday from 9am to 1pm and Monday to Friday from 4.30pm to 8pm (by appointment only). Appointments are booked via the surgery or through NHS 111. GPs are able to book advance appointments for their patients on Saturday and Sundayand on the same day for weekday evening appointments. Patients are seen by a Greenwich GP with access to their GP medical records. Details of patient consultations are recorded directly onto the patient's registered GP's records. Both Access Hub sites were four miles from the surgery.

Why we carried out this inspection

We had previously carried out an announced comprehensive inspection of this location on 27 January 2016. The overall rating at that inspection was good and the ratings for the safe, effective, caring, responsive and

well-led key questions were good. The full report for this inspection can be found by selecting the 'all reports' link for Plumbridge Medical Centre on our website at www.cqc.org.uk.

We carried out a further comprehensive inspection of this service on 27 September 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is still 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced comprehensive inspection on 27 September 2017.

During our inspection we:

- Spoke with a range of staff including the lead GP, Practice Nurse, Practice Manager and reception staff.
- Spoke with patients who used the service.
- Reviewed a sample of the patient records.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia).

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. However, not all staff were aware that a form was available. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed incident reports and minutes of meetings where significant events were discussed by clinical staff. The practice had recorded details of two significant events in the previous 12 months. The lead GP and Practice Manager informed us that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received appropriate support and were told about any actions to improve processes to prevent the same thing happening again.
- We were told that patient safety alerts, such as those produced by the MHRA, were received by the Practice Manager and passed to the lead GP to action. However, no records were kept of action taken as result of alerts received and no records were kept to confirm that the information was passed to other clinical staff where appropriate.
- We saw some evidence that lessons were shared and action was taken to improve safety in the practice. For example, we saw minutes of a clinical meeting discussing a patient who had been diagnosed with cancer which had been identified through the routine national screening programme. (The patient had experienced no symptoms). As a result, the practice put up posters in the waiting area to promote the uptake of national screening programmes.

Overview of safety systems and processes

The practice had systems and processes in place to minimise risks to patient safety but these were not always sufficiently structured or complete.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP provider was the lead for safeguarding. We were told that the GP attended safeguarding meetings and provided reports when required by other agencies.
- Staff we interviewed demonstrated they understood their responsibilities regarding safeguarding and all clinical staff had received training on safeguarding children and vulnerable adults relevant to their role. The GPs and nurse were trained to child safeguarding level three. However, some administration staff recruited in the previous five months had not yet undertaken safeguarding training. The practice had recently purchased on-line training to enable them to train staff as appropriate.
- A notice in the waiting room advised patients that chaperones were available if required. We were informed that all administrative staff acted as chaperones. However, not all staff had been trained for the role or received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The GP provider was the infection prevention and control lead for the practice. There was an infection control policy in place but administrative staff had not received up to date training and an infection control audit had not been undertaken in the previous two years.

The arrangements for managing medicines and vaccines in the practice (including obtaining, prescribing, recording, handling, storing, security and disposal) were not sufficiently effective in minimising risks to patient safety.

- There were processes in place for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits with the support of the local

clinical commissioning group pharmacy teams to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use.

- Patient Group Directions had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation. These were out of date and had not been signed by the current practice nurse. However, the practice nurse, who had commenced working at the practice only one week prior to the inspection, confirmed that she had informed the practice manager that current versions of the PGDs were required. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- There was a cold chain policy and a fridge temperature recording log in place. However, the policy did not include details of the action staff should take if temperatures fell outside of the accepted range and the temperature log did not include a facility to record the action taken. Fridge temperatures were recorded daily. However, the inspection team were concerned that the recorded temperatures were not accurate as temperatures recorded were consistently the same for maximum and minimum temperatures which would suggest that the thermometer was not correctly reset following each daily recording.

We reviewed 10 personnel files and found that not all records included evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment. However no fire drills had been carried out since 2015. The Practice Manager was the designated fire marshal within the practice. Staff were aware of how to support patients with mobility problems to evacuate the premises.
- All electrical and clinical equipment was checked and calibrated annually to ensure it was safe to use and in good working order. The practice did not have a portable fridge thermometer in order to monitor that the integral fridge thermometer was accurate but the integral fridge thermometer was checked during the annual fridge service.
- The practice had risk assessments to monitor safety of the premises such as legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to respond to emergencies and major incidents.

- There was a panic alarm in reception which alerted staff to an emergency.
- Staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. However, one of the medicines we checked had expired and there was no system in place to regularly monitor that emergency equipment and medicines were in working order and in date.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan did not include emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2015/16) showed the practice had achieved 93% of the total number of points available compared with the clinical commissioning group (CCG) average of 89% and national average of 95%.

The overall clinical exception reporting rate for the practice of 3% was below the CCG average of 7% and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

The practice was comparable to the CCG and national average for most indicators. For example:

- Performance for asthma related indicators of 100% was comparable to the CCG average of 93% and national average of 97%.
- Performance for dementia related indicators of 100% was comparable to the CCG average of 94% and national average of 97%.
- Performance for mental health related indicators of 86% was comparable to the CCG average of 84% and national average of 93%.
- Performance for diabetes related indicators of 75% was comparable to the CCG average of 78% but below the national average of 90%.

Exception reporting for these indicators was below the CCG and national average.

QOF data for 2015/16 showed the practice was an outlier for only one QOF indicator:

- The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 12 months who had been reviewed within required timescales was 67% which was below the CCG average of 79% and national average of 83%.
- The exception reporting rate for this indicator of 0% was significantly below the CCG average of 19% and national average of 22%.

There was limited evidence of clinical audit to inform quality improvement. There had been only two clinical audits commenced in the last two years both of which were single cycle audits. One audit, which reviewed the outcome of 2-week cancer referrals made by the practice between December 2016 and May 2017 resulted in changes being implemented in the practice. A 'safety net' procedure was introduced to ensure all patients referred via the urgent referral system had attended an appointment. The effectiveness of the new procedure had however not been audited.

Effective staffing

Evidence we reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had a basic induction programme for newly appointed staff. This included a brief overview of safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The Practice Nurse who administered vaccines and took samples for the cervical screening programme had received specific training which had included an assessment of competence. They were able to demonstrate how they stayed up to date with changes to the immunisation programmes by access to on line resources.
- Staff had not received an appraisal in the 12 months prior to the inspection. Learning needs of administrative staff had therefore not been identified and staff had not had access to appropriate training to meet their basic training needs. All staff received annual basic life support training. However, some administrative staff

Requires improvement

Are services effective?

(for example, treatment is effective)

had not received training in safeguarding, fire safety awareness and information governance. The provider informed us they had recently purchased access to an on-line training programme to address this.
- The lead GP was available in the practice daily to offer support to the practice nurse who had commenced working at the practice in the week prior to the inspection.
- Support was available for revalidating GPs and nurses.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system. This included care and risk assessments, care plans, medical records and investigation and test results.

From the sample of records we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a quarterly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people clinical staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example, patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The 2015/16 uptake rate for cervical screening was 75%, which was comparable with the CCG average of 80% and the national average of 81%. The practice demonstrated how they encouraged uptake of the screening programme by offering reminders for patients who did not attend for their cervical screening test and ensuring a female sample taker was available. The practice followed up women who were referred as a result of abnormal results. There was no failsafe system in place to ensure results were received for all samples sent for the cervical screening programme.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer. The provider was aware that the practice uptake rates for national screening programmes was below the national average and had recently put up posters in the waiting area encouraging patients to attend for screening. The most recent data obtained from Public Health England shows that in 2015/16:

- 48% of females aged 50 to 70 years had been screened for breast cancer in the previous 36 months compared with the local average of 62% and national average of 72%
- 37% of females aged 50 to 70 years had been screened for breast cancer within 6 months of invitation compared with the local average of 68% and national average of 73%
- 28% of people aged 60 to 69 years had been screened for bowel cancer in last 30 months compared with the local average of 47% and national average of 59%
- 23% of people aged 60 to 69 years had been screened for bowel cancer within 6 months of invitation compared with the local average of 50% and national average of 56%

Requires improvement

Are services effective?

(for example, treatment is effective)

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates of 85% for the vaccines given to children under two years were below the national target of 90%. The practice had liaised with the health visiting service to identify ways of improving uptake.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.
- Reception staff knew that if a patient wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

We received 35 patient Care Quality Commission comment cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with eight patients. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that most staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in July 2017 showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to the clinical commissioning group (CCG) and national average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said the GP was good at listening to them compared with the CCG average of 86% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 86%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 86%.
- 93% of patients said the nurse was good at listening to them compared with the CCG average of 86% and the national average of 91%.
- 93% of patients said the nurse gave them enough time compared with the CCG average of 87% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 95% and the national average of 97%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.
- 92% of patients said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 78% and the national average of 82%.
- 93% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 90%.

Good

Are services caring?

- 96% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 80% and the national average of 85%.

The practice provided facilities to help involve patients in decisions about their care:

- Staff told us that interpreting services were available for patients who did not have English as a first language but there were no notices in the reception area informing patients this service was available. All staff within the practice were multi-lingual and patients were told that these staff were available to support them if required.
- Information leaflets were available in the waiting room on a number of health related subjects.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted staff if a patient was also a carer. The practice had identified only six patients as carers on the patient record system (0.2% of the practice list). Staff told us that there were patients who were known to the GPs as carers but their carer status had not been recorded on the patient record system. Leaflets were available in the waiting area to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Staff told us there was no process in place to contact families that had experienced bereavement but the GP would contact them if they were known to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours until 7.30pm on Monday for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and for patients that required one.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that required a same day consultation.
- Patients were able to receive travel vaccines available on the NHS. Patients were referred to other clinics for vaccines available privately.
- The premises and toilet facilities were accessible to patients in a wheelchair.
- Interpreting services were available. All staff within the practice was multi-lingual and patients were told that these staff were available to assist with interpreting if required.

Access to the service

The surgery reception and telephone lines were open between 8am and 6.30pm Monday to Friday. The reception was also open for extended hours on Monday until 7.30pm.

GP appointments were available daily between 9.20am and midday and 4pm to 6pm. Extended hours appointments were available until 7.30pm on Monday. There was an average of 29 GP appointments available each day.

Appointments were available with the practice nurse between 2pm and 6pm on Tuesday and between 10am and 2pm on Friday.

Results from the national GP patient survey showed that patient's' satisfaction with how they could access care and treatment was above the clinical commissioning group (CCG) and national averages.

- 87% of patients were satisfied with the practice's opening hours compared with the CCG average of 75% and the national average of 76%.
- 88% of patients said they could get through easily to the practice by phone compared with the CCG average of 70% and the national average of 71%.
- 87% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 81% and the national average of 84%.
- 83% of patients said their last appointment was convenient compared with the CCG average of 76% and the national average of 81%.
- 90% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 58% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 51% and the national average of 58%.

Patients told us on the day of the inspection that they were usually able to get appointments when they needed them.

The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. The GP would telephone the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- There was limited information available to help patients understand the complaints system.

The practice told us they had received no complaints directly from patients in the past 12 months but had identified all negative reviews and comments received via NHS Choices and the Friends and Family Test.

- We looked at the three anonymous negative reviews received by the practice via NHS Choices. The practice had recorded these as complaints and had discussed the issues raised to identify improvements to be made. However, the practice had not placed a response to the reviews on NHS Choices.
- We also looked at the six negative reviews received via the Friends and Family Test. The practice had recorded these as complaints and had discussed the issues raised in order to identify appropriate improvements.

There was a process in place to identify lessons learnt from investigations and analysis of complaints and trends. However appropriate improvements were not always identified and therefore appropriate action was not always taken to implement improvements where required. For example, there were two negative responses received, regarding confusion and difficulty booking appointments for the child health surveillance service at the practice. However, there was no reference to any action being taken as a result of this.

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 had a vision to deliver quality care and promote good outcomes for patients. The practice had a mission statement which specified that they aimed to 'Deliver the best possible monitored, audited and continually improving quality healthcare services for our patients within a confidential and safe environment'. The practice did not however have adequate governance systems in place to ensure the achievement of this aim.

Governance arrangements

The practice did not have an effective overarching governance framework to support the delivery of their strategy and ensure the delivery of good quality care.

- Staff were aware of their own roles and responsibilities. The lead GP and Practice Nurse had lead roles in key areas. For example, the newly appointed Practice Nurse told us she was to introduce clinics for patients with asthma and chronic obstructive pulmonary disease (COPD).
- Practice specific policies were implemented and were available to all staff. These did not however all include a review date.
- The provider and Practice Manager had a comprehensive understanding of the performance of the practice but this was not shared with other members of staff. No practice meetings had been held in the previous 12 months to share this information.
- A programme of internal clinical audit had not been developed or implemented. There had been only two one-cycle clinical audits undertaken in the previous two years with limited evidence of quality improvement.
- We were told that issues raised as a result of complaints from patients were discussed with staff and appropriate action taken. However, the practice did not maintain records of action taken and lessons shared with staff.

Leadership and culture

On the day of inspection the provider told us they prioritised safe, quality and compassionate care.

Staff told us the Practice Manager was approachable and took the time to listen to members of staff.

- The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Not all staff were fully aware of their responsibilities regarding the reporting process of safety incidents.
- The practice held minuted multi-disciplinary meetings with district nurses and health visitors to monitor vulnerable families and safeguarding concerns.
- Staff were not involved in discussions about how to run and develop the practice. Staff told us they did not have the opportunity to discuss issues at team meetings as no practice meetings had taken place for over a year. However, staff told us they felt confident to raise issues with the Practice Manager if necessary.

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

The provider informed us they valued feedback from patients and staff.

- They informed us they proactively sought feedback from patients through the patient participation group (PPG). However, the provider did not have an active PPG at the time of the inspection. They were currently advertising for patients to join a 'virtual group' to be contacted by email. Enrolment forms were available on the website.
- Results of the monthly Friends and Family survey were reviewed regularly by the provider. Negative comments were discussed and improvements identified.
- Administrative staff told us that they were able to discuss concerns with the Practice Manager but there was limited opportunity to discuss issues with the other staff, especially their peers, as they usually worked alone and practice meetings did not take place in which concerns and ideas could be shared.

Continuous improvement

There was little evidence of continuous learning and improvement within the practice. The provider participated personally in local schemes to improve outcomes for patients, such as Year of Care but staff were not encouraged to undertake training and development appropriate to their role. (The Year of Care is about improving care for people with long-term conditions by supporting them to self-manage their condition).

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.: Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services: The provider did not ensure there was a safe and effective cold chain procedure in place. The provider did not have a process is in place to ensure results were received for all cervical screening samples sent for testing. The provider did not carry out necessary employment checks for all staff. The provider did not ensure that patient group directions were in date and signed by all relevant personnel. The provider did not ensure that all staff undertaking chaperone duties were trained for the role and had received a Disclosure and Barring Service (DBS) check. The provider did not ensure that there was an appropriate procedure in place for the management of safety alerts, such as those produced by the MHRA. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Maternity and midwifery services

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

How the regulation was not being met:

The registered person did not ensure that persons employed by the service received appropriate, training, professional development and appraisal:

The provider did not ensure that a programme of annual appraisals for all staff was in place.

The provider did not ensure that all staff were provided with the opportunity to undertake training appropriate to their role.

This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.