The Roehampton Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 8

What people who use the service say 11

Detailed findings from this inspection

Our inspection team 12

Background to The Roehampton Surgery 12

Why we carried out this inspection 12

How we carried out this inspection 12

Detailed findings 14

Action we have told the provider to take 25

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Roehampton Surgery on 14 April 2016. Overall the practice is rated as requires improvement.

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

- There was no effective system in place to identify and monitor risks to patients and keep them safe, for instance in regards to fire safety.
- While the practice had systems in place for staff to be trained and for meetings, there were limited or no records to confirm this.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, there was not an effective system in place for identifying, recording and investigating incidents and learning from them.
- Data showed patient outcomes were low compared to the national average for a number of clinical areas such as diabetes care.
- Although some audits had been carried out, we saw no evidence that audits were driving improvements to patient outcomes.
- The practice did not have an effective system in place for handling complaints and feedback.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

The areas where the provider must make improvements are:

- Introduce effective processes for managing significant events, incidents and near misses.
- Take action to address identified concerns with infection prevention and control practice.
- Implement systems for assessing and monitoring risks to patients including carrying out fire risk assessments and health and safety risk assessments at each site.
- Ensure staff acting as chaperones are suitably trained, with the necessary checks through the Disclosure and Barring Service.
- Ensure recruitment arrangements include all necessary employment checks for all staff.

Summary of findings

- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision, and the recording of meetings, their outcomes and actions.
- Implement effective arrangements for the identification, recording, investigation, action and learning from complaints and feedback.
- Install an Automatic External Defibrillator (AED) at each site or carry out a risk assessment as to why an AED should not be installed at each site.
- Have a programme of quality improvement, including clinical audit, to improve patient outcomes.

In addition the provider should:

- Re-introduce a patient participation group.
- Maintain a register of, and monitor and improve services for, carers.
- Consider advertising translation services and the availability of a private room so patients are aware of these 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 providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- Patients were at risk of harm because risks to patients who used services were not assessed, the systems and processes to address these risks were not implemented to ensure patients were kept safe. For example:
- Non clinical staff acting as chaperones were not trained for the role and had not had checks completed through Disclosure and Barring Service (DBS) (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 had not carried out a fire risk assessment, or implemented any fire detection and prevention measures such as alarms and fire extinguishers.
- The practice had not undertaken adequate pre-employment checks for all staff, such as checks through the Disclosure and Barring Service (DBS), photo identification checks and references from previous employers.
- The practice had not acted to address improvements required as the result of an NHS England infection control audit carried out in 2014.
- The practice did not have an Automatic External Defibrillator (AED) for use in medical emergencies, or a risk assessment as to why this equipment was not required.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- Data showed patient outcomes were low compared to the national average for some indicators, including:
- The percentage of patients with diabetes who had influenza vaccination in the preceding 1 August to 31 March was 69% compared to the national average of 94%.

Summary of findings

- The percentage of patients with diabetes whose last measured total cholesterol (measured within the preceding 12 months) was 5mmol/l or less was 58% (national average 81%).
- The percentage of patients in whom the last IFCC-HbA1c (a blood glucose level test) is 64mmol/mol or less in the preceding 12 months was 63% (national average 78%).
- The percentage of patients diagnosed with dementia whose care was reviewed in a face-to-face review in the preceding 12 months was 69% compared to the national average of 84%.
- The average daily quantity of hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 1.22, compared to the national average of 0.26.
- The number of antibacterial prescription items prescribed per STAR PU was 0.42 compared to the national average of 0.27.
- There was no evidence that audit was driving improvement in patient outcomes.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice above others for several aspects of care, for example:
- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw that staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

Summary of findings

- Patients 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.
- Information about how to complain was available in reception and on the practice website, however the information was not consistent. Staff told us that complaints were often dealt with immediately. Complaints were not recorded and staff told us that learning from complaints was shared however this was not recorded.
- The practice offered extended hours during the week for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice had appointments available specifically for children after school hours each day.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice did not have a programme of continuous clinical and internal audit to monitor quality and to make improvements.
- There were limited or no arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- A comprehensive understanding of the performance of the practice was not maintained.
- Regular clinical and whole practice meetings took place but these were not recorded, including attendance, agendas, minutes or actions.
- At the time of the inspection the practice Patient Participation Group (PPG) was inactive, however the practice told us they had plans to reinstate the group and we saw evidence that that the group had previously assisted the practice to make improvements.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities, and the responsibilities of others.

Summary of findings

- Practice specific policies were implemented and were available to all staff.

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 provider was rated as requires improvement for being safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for being safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

Performance for diabetes related indicators was similar to or below the national average for patients with diabetes on the practice register. For Example:

- The percentage of patients with diabetes who had influenza vaccination in the preceding 1 August to 31 March was 69% compared to the national average of 94%.
- The percentage of patients with diabetes whose last measured total cholesterol (measured within the preceding 12 months) was 5mmol/l or less was 58% (national average 81%).
- The percentage of patients with diabetes in whom the last IFCC-HbA1c (a blood glucose level test) was 64mmol/mol or less in the preceding 12 months was 63% (national average 78%).
- The percentage of patients with diabetes in who the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 77% (national average 78%).
- The percentage of patients with a record of a foot examination and risk classification within the preceding 12 months was 92% (national average 88%).
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and 74% of diabetes patients had a structured annual review to check their health and medicines needs were being met.

Summary of findings

Families, children and young people

Requires improvement 

The provider was rated as requires improvement for being safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- The percentage of women aged 25-64 whose notes recorded that a cervical screening test has been performed in the preceding five years was 68%, which was lower than the Clinical Commissioning Group (CCG) average of 80% and the national average of 82%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children; however, there were no baby changing facilities available.

Working age people (including those recently retired and students)

Requires improvement 

The provider was rated as requires improvement for being safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

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

People whose circumstances may make them vulnerable

Requires improvement 

The provider was rated as requires improvement for being safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients; however, these meetings were not recorded.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for being safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- 69% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was below the national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia; however, these meetings were not recorded.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. There were 393 survey forms distributed and 119 were returned. This represented 2% of the practice's patient list.

- 68% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 88% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 83% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 34 comment cards which were all positive about the standard of care received. There were lots of comments from patients who had been registered with the practice for a long time and were happy with the care they received. Some comments referred to improvements the practice had made to, for instance, the telephone system. All of the comment cards were complimentary about staff, both clinical and non-clinical, at the practice.

We spoke with 18 patients during the inspection. All 18 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Two patients who had used the practice's complaints procedure told us that their issue was dealt with promptly and that they received a full explanation and that they were satisfied with the outcome.

The latest friends and family test results showed that 100% of respondents would recommend the practice to a friend or family member.

The Roehampton Surgery

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 adviser, a second CQC inspector, a practice manager specialist adviser and an Expert by Experience.

Background to The Roehampton Surgery

The Roehampton Surgery provides primary medical services in Wandsworth to approximately 5,800 patients and is one of 44 member practices in the NHS Wandsworth Clinical Commissioning Group (CCG). The practice operates under a General Medical Services (GMS) contract and provides a number of local and national enhanced services (enhanced services require an increased level of service provision above that which is normally required under the core GP contract).

Wandsworth has 50% more 20 to 40 year olds, but 33% fewer older people than other south west London boroughs, and this is reflected in the patient demographics for the practice with 18% of patients aged 65 or over, 62% of patients aged 18-65 years old and 20% aged 18 or younger.

The practice population is in the fifth most deprived decile, with income deprivation affecting children and older people above CCG and national averages.

The practice operates from a converted residential property with three floors. On the ground floor are a reception area, waiting area, treatment room and consultation rooms. There is also a patient toilet which is wheelchair accessible on the ground floor.

On the first floor there are rooms for staff facilities, a meeting room, a room used by the local counselling service and a waiting room for their patients. The second floor of the building is primarily used for storage and is not accessed by patients.

The building is wheelchair accessible via a ramp. There are no automatic doors; however, staff told us they would assist entry for any patient who needed help. There is no lift between floors; the practice told us they only see patients on the ground floor. There is no hearing loop at reception; staff told us that they would communicate in other ways with patients with hearing impairments such as in writing or use a free area of the practice to talk in private. There are no baby changing or breast feeding facilities.

The practice clinical team is made up of one female GP partner, one male GP partner and one female nurse. The practice also has one male and one female part time regular locum GP. A healthcare assistant (HCA) who previously worked as a receptionist at the practice has recently been appointed but at the time of the inspection had not completed their training. The non-clinical team consists of one IT manager, one office manager, three senior reception staff and two administrative staff. The practice had not had a practice manager in post for two years.

The practice opens between 8.30am and 6.30pm Monday to Friday. Telephone lines are operational between the hours of 8.30am and 1.00pm and 3.30pm and 6.30pm on a Monday, Tuesday, Thursday and Friday. On Wednesdays

the telephone lines are operational between the hours of 8.30am and 6.30pm. Extended hours are available Monday to Thursday from 6.30pm to 8.00pm. Appointments during extended hours are pre-bookable only.

The provider has opted out of providing out-of-hours (OOH) services to their own patients, directing them to seek assistance from the locally agreed OOH provider during the following times; Monday, Tuesday, Thursday and Friday between 1.30pm and 3.30pm, between 6.30pm and 8.30am Monday to Friday and at all times on weekends.

The practice also operates some of its registered activities from another site located at 105 Carslake Road, Putney Heath, SW15 3DD, known locally and to staff and patients as the Ashburton Medical Practice. The site opens between the hours of 8.30am and 11.30am Monday to Friday and between 4.00pm and 6.00pm on Friday. Appointments are available at these same times. Telephone lines operate between these same hours. This site was visited as part of the inspection.

The provider is registered with the Care Quality Commission to provide the regulated activities of Diagnostic and Screening Services, Maternity and Midwifery Services, Family Planning, Treatment of Disease, Disorder and Injury.

The provider has previously been inspected by the CQC in November 2013 and met all of the required standards.

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. The 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.

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 visit on 14 April 2016. During our visit we:

- Spoke with a range of staff including GP partners, practice nurse, the office manager and reception staff.
- Spoke with 18 patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 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 not an effective system in place for reporting and recording significant events.

- Staff told us they would inform the office manager or a GP partner of any incidents. However, a recording form or similar was not available.
- We saw no examples to demonstrate whether when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again, however the practice told us that this would happen should the situation occur.
- Prior to the inspection, the practice sent us a summary of four significant events that had taken place in the previous 12 months. Staff told us they carried out an analysis of significant events but we saw limited written evidence to demonstrate this such as meeting minutes or records of actions being carried out. An example of a significant event the practice gave us was that of a staff member who slipped and fell in the treatment room, sustaining a back injury. The incident was investigated to check that there were no hazards such as water spillage on the floor. The practice provided support during the recovery period including investigating and arranging necessary treatment. The staff member returned to work after a full recovery. The practice lessons identified were to ensure provision of a safe and non-hazardous working environment, however we saw no evidence that a practice hazard assessment had taken place.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse 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. There was a lead member of staff for safeguarding and non-clinical staff gave us examples of where they had effectively used the practice safeguarding arrangements. The GPs told us they attended safeguarding meetings when possible and always provided reports where necessary for other agencies, however there were no records to verify this. Staff demonstrated they understood their responsibilities and all told us they had received training on safeguarding children and vulnerable adults relevant to their role; however, there were few records available to verify this. For example, the practice nurse told us that they had attended the same level 3 safeguarding training as the GP partners, however there were no certificates or other evidence to support this. GPs were trained to child safeguarding level 3 and we saw certificates to this effect.
- A notice in the waiting room advised patients that chaperones were available if required. Non-clinical staff who acted as chaperones were informally and inconsistently trained for the role and had not received a standard or enhanced Disclosure and Barring Service (DBS) check and a risk assessment had not been carried out to determine that the chaperones did not need a 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). Clinical staff acting as chaperones had received a DBS check and informal chaperone training.
- We observed the premises to be tidy and most patient and staff areas were clean. There were areas of the main practice and the branch surgery that we found to be unclean and dusty, including staff toilets, sinks in staff areas, bin lids in staff areas, carpeted areas, window ledges and shelves. There were also cracked windows in both sites. The practice nurse had been assigned the infection control clinical lead role four weeks before the inspection; they had liaised with the local infection prevention teams to keep up to date with best practice and had engaged with the practice partners to apply best practice. Previously a GP partner was the lead for infection control. Non-clinical staff had received informal training at ad hoc practice meetings. Annual infection control audits were not undertaken and we saw evidence that action had not been taken to address improvements identified as a result of an audit conducted in 2014 by the local NHS England infection control lead.

Requires improvement

Are services safe?

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored at the main site and there were systems in place to monitor their use; however, at the branch site we found unsecured blank prescriptions in printers and under the reception desk and the building was not occupied.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (Patient Group Directions allow an approved, competent individual or group of individuals to administer medicines such as vaccines to a group of patients)
- We reviewed six personnel files and found appropriate recruitment checks had not been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service had not been checked or carried out prior to employment in any of the files we reviewed. The practice had a recruitment policy in place which was not being followed consistently and did not cover all of the above required recruitment checks.

Monitoring risks to patients

Risks to patients were not assessed or well managed.

- There were limited or no procedures in place for monitoring and managing some risks to patient and staff safety, for example;
- There was no health and safety policy available and no poster identifying local health and safety representatives. The practice had not carried out a health and safety risk assessment.
- The practice had not carried out a fire risk assessment and had not carried out regular fire drills. There was no fire detection or fire prevention equipment such as fire alarms or fire extinguishers. Clinical equipment was checked to ensure it was working properly and safe to use. Some, but not all, non-clinical electrical equipment was checked to ensure the equipment was safe to use. These checks had been carried out the day before the inspection, and we saw no evidence these checks had been carried out regularly in the past.
- The practice did have other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Staff had received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had oxygen with adult and children's masks at both sites but did not have a defibrillator available at either site and the practice had not conducted a risk assessment in relation to this. A first aid kit and accident book were available at the main site, however not at the branch site.
- Emergency medicines were easily accessible to staff in a secure area of the practice main site and all staff knew of their location. All the medicines we checked were in date and stored securely.
- Emergency medicines were not stored, other than for anaphylaxis, at the practice branch site. Staff told us that there would always be a GP present when the site was open and that emergency medicines were carried in their doctor's bag. We checked the doctor's bag and found there were appropriate emergency medicines within.

Requires improvement

Are services safe?

- The practice had a business continuity plan in place for major incidents such as power failure or building damage, however staff were not aware of the plan and 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

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date.
- 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 audits.

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 were 87% of the total number of points available. Clinical domains where exception reporting was significantly higher than the Clinical Commissioning Group (CCG) and national averages include cancer where the practice value was 54.5% compared to the CCG average of 9.9% and the national average of 15.4%. The practice could not account for these figures. (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).

Clinical domains where exception reporting was significantly below CCG and national averages include:

- Depression at 10% exception reporting compared to the CCG average of 23% and the national average of 24%
- Atrial fibrillation (a heart condition) at 1% exception reporting (CCG average 12%, national average 11%)
- Mental health at 0.4% exception reporting (CCG average 7%, national average 11%)
- Cardiovascular disease at 0% exception reporting (CCG average 26%, national average 30%)
- Osteoporosis at 0% exception reporting (CCG average 7%, national average 11%)
- Rheumatoid arthritis at 0% exception reporting (CCG average 2%, national average 7%)

Accounting for these figures, the practice told us that they do not routinely exception report.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

Performance for diabetes related indicators was similar to or below the national average for patients with diabetes on the practice register. For example:

- The percentage of patients with diabetes who had influenza vaccination in the preceding 1 August to 31 March was 69% compared to the national average of 94%.
- The percentage of patients with diabetes whose last measured total cholesterol (measured within the preceding 12 months) was 5mmol/l or less was 58% (national average 81%).
- The percentage of patients with diabetes in whom the last IFCC-HbA1c (a blood glucose level test) was 64mmol/mol or less in the preceding 12 months was 63% (national average 78%).
- The percentage of patients with diabetes in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 77% (national average 78%).
- The percentage of patients with a record of a foot examination and risk classification within the preceding 12 months was 92% (national average 88%).

Performance for mental health related indicators was similar to the national average. For example:

- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 69% compared to the national average of 84%.
- The percentage of patients with physical and/or mental health conditions whose notes recorded smoking status in the preceding 12 months was 91% (national average 94%).
- The percentage of patients with schizophrenia, bipolar affective disorder, and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 86% (national average 88%).

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of patients with schizophrenia, bipolar affective disorder, and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 92% (national average 90%).

Performance for prescribing indicators was below the national average for hypnotics and antibiotics prescribed to patients, for example:

- The average daily quantity of hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 1.22, compared to the national average of 0.26.
- The number of antibacterial prescription items prescribed per STAR PU was 0.42 compared to the national average of 0.27.

The practice could not account for these figures.

There was no evidence of clinical audit driving improvement.

- There had been two clinical audits conducted in the last two years, both of these were completed audits, although these audits were instigated by the local Clinical Commissioning Group (CCG) rather than the practice addressing identified patient need. The practice did not have a programme of continuous clinical audit.
- The practice could not provide evidence they had participated in local audits, national benchmarking, accreditation, peer review or research.
- The practice could not provide evidence that information about patients' outcomes was used to make improvements.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment, although records did not confirm this.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions and those giving vaccinations had update training, however this was not clearly evidenced.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines told us they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings, however this was not recorded.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months; however these were not always clearly recorded with dates, signatures or details of discussions had and development plans.
- Staff received training that included: safeguarding, basic life support and information governance. Staff told us they had access to and made use of e-learning training modules and in-house training, however a central training log and individual training certificates were not present for all staff for all training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- 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 monthly basis when care plans were routinely reviewed and updated for patients with complex needs; however these meetings were informal and not recorded.

Consent to care and treatment

Requires improvement

Are services effective?

(for example, treatment is effective)

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, 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.
- GPs told us consent was requested in line with requirements although there was no system for the practice to monitor this through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Diet and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 66%, which was below the CCG average of 81% and the national average of 82%. The practice demonstrated how they encouraged uptake of the screening programme by sending reminder letters, using information for those with a learning disability, in different languages, and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 66% to 87% and five year olds from 53% to 83%.

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

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were not provided in consulting rooms but were available in the treatment room to maintain patients' privacy and dignity during examinations, investigations and treatments. GPs told us they would use the treatment room for examinations of patients.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard in the reception area.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 34 Care Quality Commission patient comment cards we received 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.

The practice had previously had a patient participation group (PPG), but the PPG was inactive at the time of the inspection.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice performance for its satisfaction scores on consultations with GPs and nurses was average. For example:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% 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. We also saw that care plans were personalised.

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:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%

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

- Staff told us that translation services were available for patients who did not have English as a first language. However the practice did not have notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- Staff told us they provided specific information in other languages, for example, diabetes information, and signposted patients to other sources of information where necessary.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

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. Information about support groups was also available on the practice website.

The practice did not hold a separate register of carers but GPs told us they knew who their patients who were also carers were and would direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example;

- The practice offered extended hours Monday to Thursday from 6.30pm to 8.00pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- The practice had appointments available specifically for children after school hours each day.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available, but there was no hearing loop for patients who had hearing difficulties. Staff told us that they assisted patients with hearing difficulties by; offering a private area where louder voices could be used, writing conversations down and offering British Sign Language (BSL) interpreters for appointments.
- The practice had not installed baby change facilities or identified specific areas for breast feeding mothers.
- We noticed staff assisting patients where needed, for instance in escorting them to a consultation, however we also saw patients struggling to rise from waiting room chairs without arms.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Telephone lines were operational between the hours of 8.30am and 1.00pm and 3.30pm and 6.30pm on a Monday, Tuesday, Thursday and Friday. On Wednesdays the telephone lines were operational between the hours of 8.30am and 6.30pm. Extended hours were available Monday to Thursday from 6.30pm to 8.00pm appointments were available at these same times.

Appointments during extended hours were prebookable only. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to national averages.

- 74% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 68% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

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

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Home visits were determined by the GP telephoning 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 did not have an effective system in place for handling complaints and concerns.

- The practice did not have a complaints policy.
- Complaints information was available in reception and on the practice website, however this information was inconsistent, for example;
- The practice website referred patients with complaints to contact the practice manager by phone or in writing; however, the practice does not currently have a practice manager.
- Staff told us that they would receive verbal complaints which were usually dealt with there and then or referred to a GP.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- There was a designated responsible person, a GP partner, who handled all complaints in the practice, however complaints received, actions, outcomes and patient contact were not recorded.

The practice told us they had received one verbal complaint and no written complaints in the last 12 months. We saw a summary of the verbal complaint that the practice submitted as part of their pre-inspection data; however, they did not provide a record of this complaint on the day of the inspection. We did not find evidence that lessons were learnt from individual concerns and complaints or from analysis of trends or that action was taken as a result to improve the quality of care.

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 mission statement displayed in the waiting area. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. All staff shared this vision; however the practice did not have a robust strategy and supporting business plans, regularly monitored and reviewed, which reflected the practice's vision and values.

Governance arrangements

The practice did not have an overarching governance framework which supported the delivery of the strategy and good quality care, for example:

- The practice did not have a programme of continuous clinical and internal audit to monitor quality and to make improvements.
- There were limited or no arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- A comprehensive understanding of the performance of the practice was not maintained.
- Regular clinical and whole practice meetings took place but these were not recorded, including attendance, agendas, minutes or actions.

However;

- There was a clear staffing structure and staff were aware of their own roles and responsibilities, and the responsibilities of others.
- Practice specific policies were implemented and were available to all staff.

Leadership and culture

Staff told us the partners were approachable and always took the time to listen to all 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). However the practice could not demonstrate these systems had been used. The partners encouraged a culture of openness and honesty.

The practice told us it had systems in place to ensure that when things went wrong with care and treatment, they gave affected people reasonable support, truthful information and a verbal and written apology. However, the practice could not demonstrate when these had been used as the practice did not keep written records of verbal interactions or written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings, however these were not recorded.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- We noted team away days were held every 12 months.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice; however there was no written evidence of this.

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

The practice encouraged feedback from patients, the public and staff.

- At the time of the inspection the practice Patient Participation Group (PPG) was inactive, however the practice told us they had plans to reinstate the group and we saw evidence that that the group had previously assisted the practice to make improvements.
- For example, the PPG had identified, through a patient survey, that patient access via the telephone was problematic. The practice installed a new automatic telephone system and told us that the number of verbal complaints about telephone access had decreased. Patient satisfaction scores in the most recent GP patient survey supported this improvement.
- The practice told us they had gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues at any time.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not assess the risks to the health and safety of service users and did not do all that is reasonably practicable to mitigate any such risks. They had not carried out risk assessments for fire safety and health and safety, fire safety equipment was absent, and not all clinical equipment had been checked to ensure it was safe to use. Incidents affecting the health, safety and welfare of people using services had not been investigated thoroughly, or shared widely enough to make improvements and prevent further occurrences. The registered person did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. For example non clinical staff carrying out chaperone duties had not had appropriate training to do so. The registered person did not assess the risk of, and prevent, detect and control the spread of infections, including those that are health care associated. Action had not been taken to address concerns raised in a 2014 NHS England infection control audit. Annual internal infection control audits had not been carried out. 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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The registered person did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The practice did not maintain records in relation to persons employed in the carrying on of the registered activity or the management of the activity to enable to registered person to evaluate and improve their practice. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** Staff recruitment records did not demonstrate the provider had carried out the required checks prior to new staff starting work.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 19(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.