The Circle Practice

Quality Report

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Date of inspection visit: 5 February 2015
Date of publication: 02/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Circle Practice on 5 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, caring, responsive and well led services. It was also good for providing services for older people; families, children and young people; working age people (including those recently retired and students); people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia). It required improvement for providing effective services and services for people with long term conditions.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Systems including safeguarding measures and infection control procedures were in place to keep patients safe.
- Staff were appropriately qualified to deliver effective care and treatment in line with professional guidelines.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider must:

- Ensure Disclosure and Barring service (DBS) checks are undertaken for all staff who undertake chaperone duties at the practice or undertake a risk assessment if a decision is made not to perform DBS checks for staff providing chaperone duties.

The provider should:

- Ensure all staff providing chaperone duties understand their role and responsibilities when providing the chaperoning service.
- Ensure all patients with long term conditions are provided with a structured annual review to check that their health and medication needs are met.
- Ensure there is a proactive recall system in place to provide preventative and continuing care for patients.
- Ensure the practice business continuity plan provides a comprehensive list of contact details for staff to refer to.

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?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Staff had received training in safeguarding and they were aware of the steps to take if they had any concerns. Systems were in place to ensure medicines were managed safely and infection control standards maintained. Staff had been trained to respond to medical emergencies and plans were in place to deliver continuity of care during potential disruptions to services. A risk assessment had not been undertaken for a decision to perform Disclosure and Barring service (DBS) checks for all administrative staff who provided chaperone duties at the practice and DBS checks had not been completed for all staff providing chaperoning duties. Health and safety monitoring was being carried out and where risks were identified, control measures were in place to minimise them.There were enough staff to keep patients safe.

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 showed patient outcomes were at or below average for the locality. Follow ups and reviews for some patients were carried out opportunistically as a result of systematic recalls not being in place.

Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. The practice had a system in place for completing clinical audit cycles and we saw evidence of improved outcomes for patients as a result. Consent was sought from patients when appropriate and staff had a working knowledge of key legislation such as the Mental Capacity Act 2005. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect. The practice involved patients in decisions about their care

Summary of findings

and treatment and supported them through periods of illness or bereavement. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice was responsive to people's needs and had systems in place to maintain the level of service provided. The practice had planned services to meet the needs of the local population including extended hours for appointments and longer appointments for patients who needed them. Patients were overall satisfied with access and the practices' opening hours. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG) and had a system in place for handling concerns and complaints. Patients' complaints had been acknowledged and resolved in a timely manner.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a clear vision and strategy. There was clear leadership and staff were aware of who they were accountable to and their level of responsibility. The practice had a number of policies and procedures to govern activity. Staff had received inductions, appraisals and attended staff meetings. The practice gained feedback from staff and patients and acted on it to improve services. The patient participation group (PPG) was active. The practice used clinical audit to improve outcomes for patients

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

We found older patients were treated with dignity and respect. For example, longer appointments were available for older patients so they did not feel rushed. The practice offered a home visit service for those patients who were housebound. All patients over 75 years of age had a named GP and the practice had informed patients of this provision. Staff had completed training in recognising the signs of abuse in older patients and they were aware of the procedures to report any concerns. The practice worked with other specialists to provide effective care for older patients including end of life care.

People with long term conditions

Requires improvement

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

The practice provided clinics for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD) and GPs were appointed to act as clinical leads for long term conditions. Longer appointments were offered for patients with complex needs and home visits were available when needed. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Some patients had not been provided with a structured annual review to check that their health and medication needs were being met. Follow ups and reviews were provided for some patients opportunistically and there was no proactive recall system in place to provide preventative and continuing care.

Families, children and young people

Good

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

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. All staff were trained in safeguarding children and were aware of the procedures to follow if they were concerned about a child's wellbeing and welfare. Regular multidisciplinary team meetings were held with GPs and health visitors to discuss and monitor vulnerable children under the age of 5 years of age. The practice provided a range of services for families, babies, children and young people including child development checks and baby and child immunisations. Practice appointments were available

Summary of findings

outside of school hours and the premises were suitable for children and babies. The GPs offered family planning advice, prescribed oral contraceptives, post-coital contraceptives and provided contraceptive injections.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had extended hours two days a week and offered patients early morning appointments before 9am. Patients could book appointments and order repeat prescriptions online and telephone consultations were available on request. The practice offered a full range of health promotion and offered patients over 40 years of age an NHS health check.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice had a register of patients with learning disabilities and offered annual health checks and longer appointments for them. An interpreter service was available for patients where English was not their first language. Residents of a local homeless shelter were encouraged to register at the practice and those with temporary residence in the UK were also able to register at the practice to receive care and treatment. Patients with drug and alcohol issues were referred to local drug and alcohol services and information was displayed in the patient waiting room signposting patients to these services.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia).

The practice maintained a register of patients experiencing dementia and all clinical staff had been trained in dementia awareness and screening. Annual health checks were offered to patients on the dementia register and longer appointments were available for those with poor mental health. GPs made referrals to Improving Access to Psychological Therapies (IAPT) and Child and

Summary of findings

Adolescent Mental Health Services (CAMHS) for patients who required support. The practice also signposted patients experiencing poor mental health to various support groups and voluntary organisations including MIND and bereavement services.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection and two members of the Participation Group (PPG). We reviewed 18 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service; the results of the practice's most recent patient experience survey and the national patient survey 2014.

All the patients we spoke with were positive about the practice and the vast majority of the CQC comment cards stated that the service was 'good', 'very good' or 'excellent.' Patients said all the staff were friendly and treated them in a respectful manner. Patients were generally satisfied with the practice's opening hours and the standard of care they received. Results of the national patient survey showed that 84% of patients described their overall experience of the practice as good which was above the local CCG average of 79%.

Areas for improvement

Action the service MUST take to improve

- Ensure Disclosure and Barring service (DBS) checks are undertaken for all staff who undertake chaperone duties at the practice or undertake a risk assessment if a decision is made not to perform DBS checks for staff providing chaperone duties.

Action the service SHOULD take to improve

- Ensure all staff providing chaperone duties understand their role and responsibilities when providing chaperoning service.
- Ensure all patients with long term conditions are provided with a structured annual review to check that their health and medication needs are met.
- Ensure there is a proactive recall system in place to provide preventative and continuing care for patients.
- Ensure the practice business continuity plan provides a comprehensive list of contact details for staff to refer to.

The Circle Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a GP, Practice Nurse and Expert by Experience Specialist Advisors. The Specialist Advisors were granted the same authority to enter The Circle Practice as the CQC inspector.

Background to The Circle Practice

The Circle Practice provides GP primary medical services to approximately 8,181 patients living in the London Borough of Harrow.

The practice team is made up of two female GPs, two male GPs, a practice nurse, practice manager and seven reception staff.

The practice opening hours are between 8:00am-8:00pm Monday and Tuesday and 8.00am-6.30pm Wednesday-Friday. Telephone access is available during core hours and home visits are provided for patients who are housebound or too ill to visit the practice.

The practice has a Primary Medical Services (PMS) contract (PMS is one of the three contracting routes that have been available to enable the commissioning of primary medical services).The practice refers patients to the 'HARMONI' service for healthcare advice during Out of Hours.

The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury.

The practice provides a range of services including maternity care, family planning, sexual health, chronic disease management, childhood immunisations and travel clinics.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice including information published on the NHS choices website and the national patient survey 2014. We asked other organisations such as NHS England and Harrow Clinical Commissioning Group (CCG) to share what they knew about the service.

We carried out an announced visit on 5 February 2015. During our visit we spoke with a range of staff including GPs, a practice nurse, practice manager and reception staff. We spoke with eight patients who used the service and two members of the practice's Patient Participation Group. We reviewed comment cards completed by 18 patients sharing their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety, for example incident reports, complaints, safeguarding concerns and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns and how to report incidents and near misses. We were told of an incident where a patient had tripped over a set of weighing scales in a consultation room. The practice had taken action to prevent reoccurrence of this incident by changing the position of the weighing scales in the consultation room to prevent a trip hazard to patients. Patients we spoke with during the inspection told us they felt their care and treatment at the practice was safe.

We reviewed minutes of practice meetings where incidents and complaints were discussed during the last 12 months and reviewed incident reports which had been collated for the last five years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events and incidents were reported on a standardised form which included a description of the incident, key risk issues and specific action required to prevent a reoccurrence. The practice had a significant event policy which included a process for communicating the outcome and learning to relevant staff. Staff, including receptionists, were aware of the process to follow and reported incidents to the practice manager. Staff we spoke with were able to provide examples of recent incidents reported and told us that incidents were discussed at practice meetings to ensure all staff were kept informed. We saw evidence of significant events being discussed as part of the clinical meetings. A significant events folder containing significant events forms were in the practice office area for staff to access however, there was no electronic log of significant events available.

There were records of significant events that had occurred during the last five years and we were able to review these. An example of one significant event the practice decided to implement finger prick blood testing as a matter of course if a patient presented with the same type of symptoms in order to rule out diabetes and arranged for all consultation rooms to have access to blood glucose testing machines.

National patient safety alerts were printed and disseminated by the practice manager to practice staff and were discussed in team meetings where necessary. Staff we spoke with were able to give an example of a drug safety alert that had been disseminated to practice staff and actioned. The drug safety alert instructed that there was an increased risk of serious cardiac side effects with the use of Domperidone medication used to treat nausea and vomiting. The practice actioned this safety alert by undertaking an audit to identify patients who were contraindicated for this medication and inappropriate prescribing for these patients was stopped. All patients were reviewed and the number of patients taking the medication was reduced from 72 to 14.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a safeguarding policy in place for children which included contact details for local child protection teams. Flowcharts detailing the process for escalating safeguarding concerns were posted in consultation rooms for quick reference, to ensure staff reported any concerns promptly.

We examined training records during the inspection which included certificates of training completed. Training certificates showed that all staff had received relevant role specific training in child protection. All administrative staff were trained at Level 1 and GPs were trained at Level 3 in accordance with national guidance. The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

We asked reception staff about their most recent training. Staff we spoke to were able to describe signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Safeguarding contact details including social services and

designated child protection doctors were easily accessible and were available in a folder kept in the office area. The practice maintained a register of children who were vulnerable and at risk. There was an alert message system to highlight vulnerable patients on the practice's electronic records.

The practice had a chaperone policy and signs were visible in the waiting area and in the consultation rooms offering the chaperone service. Patients we spoke with during our inspection knew that the chaperoning service was available to them. The chaperone policy contained guidelines on who could act as a chaperone, the role of the chaperone and confidentiality requirements. The policy strongly recommended that chaperoning should be provided by clinical staff familiar with procedural aspects of personal examination. However, if clinical staff were not available to act as chaperones, administrative staff were required to provide this service. Administrative staff had been provided with online chaperone training, however some of the staff we spoke with were unclear about their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Disclosure and Barring Service checks had been performed for clinicians but not all administrative staff providing chaperone duties had undergone a criminal records check and a risk assessment had not been carried out to support this decision.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a cold chain procedure for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a breach of these temperatures. The fridge temperature was checked and documented twice a day and we saw records of these checks being undertaken and that the appropriate temperature range had been maintained.

The practice nurse was responsible for ensuring medicines were in stock and within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations, however we found one medicine in a doctor's bag which was not fit for use. This was disposed of immediately by the practice. Vaccines were administered by the practice nurse using directions that had been produced in line with legal requirements and national guidance.

There was a policy for repeat prescribing which was in line with national guidance and was followed in practice. The policy complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. We saw evidence of prescription training was part of the administration staff induction programme. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. There was no hand sanitiser available to patients in the waiting area, although we saw this was available to staff on reception. The practice was located within a health centre which was managed by NHS property services. The maintenance of the building including cleaning schedules and cleaning records, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal), was managed by NHS property services.

All staff received induction training about infection control specific to their role and received annual updates. One of the GPs was nominated as the infection control lead. We saw evidence of an infection control audit that had been carried out by an external agency and improvements identified were actioned.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the practice had a clinical waste management protocol in place and waste was segregated, stored safely and disposed of by a professional waste company. Personal protective equipment (PPE) including disposable gloves and coverings were available for staff to use to minimise cross-infection risks.

Good

Are services safe?

There was also a protocol for needle stick injuries which included immediate actions to take following an injury and contact details for needle stick injury advice from local hospitals and the occupational health department. The practice had a contract with an external agency for weekly safe removal and disposal of sharps waste.

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

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

The practice had a contract with an external agency to provide portable appliance testing (PAT) and calibration of equipment on a routine annual basis. Examples of equipment calibrated included blood pressure monitors and weighing scales. All portable electrical equipment displayed stickers indicating the next testing due dates which February and July 2015.

Staffing and recruitment

During our inspection we reviewed five staff files. The practice had a recruitment policy and the staff files we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body, employment history and references. However, we noted that criminal records checks through the Disclosure and Barring Service (DBS) had not been undertaken for some of the administrative staff who provided chaperoning duties.

The practice had an induction policy and provided a comprehensive induction for staff as part of the recruitment process. We saw an example of an induction programme for administrative staff which included procedures for repeat prescriptions.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty and there was an appropriate skill mix to facilitate the clinics being provided. Administrative staff annual leave was organised by the practice manager and locum GP's were not frequently booked for clinical sessions as the practice would try to cover staff annual leave and sickness internally.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice..

The practice had a health and safety policy and health and safety training was part of staff induction. The practice manager was the nominated health and safety representative for the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. All staff had undertaken annual basic life support training in line with national guidance. . Staff we spoke with provided an example of a medical emergency concerning a patient that the practice had discussed and learned from appropriately.

Emergency equipment was available including access to oxygen and a pulse oximeter (used to check the level of oxygen in a patient's bloodstream). All of the staff we spoke with knew the location of this equipment within the practice. The practice also had access to a defibrillator (used to attempt to restart a person's heart in an emergency) which was located in one of the medical centre's treatment rooms.

Emergency medicines were available in the practice office and the nurse's consulting room and the all staff knew of their location. We saw evidence that the emergency equipment and medication was checked regularly to ensure the stock was maintained and suitable for use. The emergency medication included those for the treatment of cardiac arrest, asthma attacks and anaphylaxis. Anaphylactic kits containing adrenalin was available in the nurses room and consulting rooms and flowchart posters were displayed with the procedure to follow in the event of a patient experiencing anaphylactic shock within the consultation rooms.

A major incident and business continuity policy was in place to deal with a range of emergencies that may impact

Good

Are services safe?

on the daily operation of the practice. Emergencies identified within the plan included loss of computer systems, medical records, telephone systems, electricity and water supplies and staffing issues. The business continuity plan did not however contain a comprehensive list of contact details for staff to refer to in the event of an emergency.

The practice had a fire safety policy, staff had received fire training and we saw evidence of fire procedure notices displayed throughout the practice. Fire alarm checks were undertaken and fire drills had been practiced to ensure patients and staff could be evacuated in the event of a fire. An external agency provided fire protection equipment servicing and a fire risk assessment for the practice had been carried out to identify actions required to maintain fire safety.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. NICE guidelines were distributed to GPs via email and these were discussed in clinical meetings where necessary. Staff we spoke with provided evidence of an example of a NICE guideline that had been implemented. The guideline related to constipation experienced by children and young people and medication for these patients was changed with the help of a pharmacist. We found from our discussions with the GPs that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The practice benchmarked their prescribing figures with other practices within the locality. GPs we spoke with told us that their antibiotic prescribing figures were slightly above other practices within the locality however, there were no specific plans to address the over-prescribing.

The GPs led in specific disease areas including asthma, chronic obstructive pulmonary disorder (COPD) and diabetes. We found that there were no systematic reviews in place for patients with asthma, COPD and diabetes. For example, reviews for diabetic patients were done on an ad-hoc basis in line with prescription alerts. The practice has a practice nurse and also shares the Treatment Room Nurse with the two other practices located within the health centre. To address this issue of lack of systematic reviews for patients, the GPs planned to work more closely with the practice nurse.

The practice was participating in the unplanned admissions Directed Enhanced Service (DES). (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Patients with risk factors such as chronic obstructive pulmonary disorder (COPD), diabetes, and patients with poor mobility who were living alone, were provided with care plans developed by the GPs. These care plans informed patient what to do when they felt unwell to prevent unnecessary attendances to A&E and hospital. The practice used a risk profiling software which enabled GPs to identify a range of at-risk patients and detect and prevent unwanted outcomes for patients. The GPs attended a multidisciplinary meeting held every three months to discuss the care plans of vulnerable patients and we saw evidence of meeting minutes in which eight patients care was discussed.

The practice used a referral management service to organise patient referrals and the local CCG produced the referral pathways. Prior to any external referral being processed, the practice had an internal referral peer review process. For example, one GP with dermatology expertise is used to peer review colleagues dermatology referrals to ensure that these are appropriate.

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

Management, monitoring and improving outcomes for people

The practice had achieved 75% in their Quality and Outcomes Framework (QOF) performance in 2013/14 which was 17% below the local CCG average. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. The GPs shared responsibility for QOF and the practices' performance was discussed at the management and clinical meetings which helped the practice to focus on areas where services to patients could be improved.

The practice had achieved 65% of the QOF points available in the clinical domains in 2013/14 and had scored below the local CCG average for a range of conditions including cancer, dementia, and chronic obstructive pulmonary disease. We found that some reviews for patients were approached in an opportunistic way rather than systematically. One patient with a long term condition we spoke with told us that he required an appointment every six months and he ensured he made this appointment as he hadn't previously been contacted by the practice when his review was due.

The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where

Requires improvement

Are services effective?

(for example, treatment is effective)

needed and the audit repeated to ensure outcomes for patients had improved. For example, following drug alert guidelines regarding a medicine used to treat moderate and severe pain, a clinical audit was carried out. The aim of the audit was to ensure that there was no unnecessary prescribing and patients were given a maximum of 28 days supply of the medication. Following the first audit, the GPs reviewed patients' medicines and patients were contacted and advised of the new prescribing guidelines for the medication. A second clinical audit was completed which demonstrated that the number of patients prescribed the medication had reduced from 128 to 32.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support and infection control. We noted a good skill mix amongst the doctors with leads for safeguarding and mental health.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England). All staff completed an induction programme when they started working for the practice.

Staff undertook annual appraisals and we saw appraisal documentation for four members of staff. However, we found the appraisal documentation focused on future changes to the post holder's role and training needs as a result of this change, as opposed to development of staff within their current posts.

Working with colleagues and other services

One of the GP partners met with the local CCG on a monthly basis to discuss areas to focus on and communicated these with all the GPs. The practice worked with other service providers to meet people's needs and manage complex cases. The GPs attended multidisciplinary team meetings every three months to discuss the needs of complex patients, for example patients experiencing poor mental health. The multidisciplinary team meeting included attendance by district and palliative care nurses and staff felt these meetings worked well and were a useful forum for sharing important information.

For patients requiring end of life care the practice holds a palliative care register of patients and works with the local palliative care team to co-ordinate and manage the care of these patients.

The practice was participating in an Enhanced Service for unplanned admissions to reduce unnecessary emergency patient admissions to secondary care by using a risk stratification tool to identify patients at risk of unplanned admission to hospital and manage their care proactively. In addition to participating in this Enhanced Service, the practice liaised with the 'STARRS' team (a short-term assessment, rehabilitation and reablement service) who provide rapid assessment for patients in their home following a referral. They develop a multi-disciplinary plan of care, supporting the patient at home to avoid admission to hospital or A&E.

The practice contacted patients following a discharge from hospital. The practice formally discussed the care of older patients with the extended primary care team which includes district nurses and palliative care team at a meeting held every three months. However, the practice found that the district nurses being based within the health centre created excellent channels of communication, often on a daily basis.

For pregnant patients and patients under five years of age, the practice held regular meetings with Health Visitors. Ante-natal care was provided for patients on a shared care basis with the practice and the local Maternity Unit and a Community Midwife ran clinics on a regular basis.

Information sharing

Electronic systems were in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system worked well. Patients we spoke with told us that following a diagnosis with the GP, referrals to see a consultant occurred quickly.

The practice had systems to provide staff with the information they needed. An electronic patient record was

used by staff to coordinate, document and manage patients' care. Staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

For information posted to the practice, such as hospital patient discharge letters, these were scanned into the practice's electronic system and assigned to the GPs to be managed. Arrangements were in place for the duty doctor to be nominated to be responsible for post received for GPs who were on leave from work. This provision facilitated urgent information received by post to be actioned despite any GP absences from the practice.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. Staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. One of the GP partners was the lead for this area and provided support for colleagues where necessary. Patients we spoke with told us that clinicians always requested their consent prior to any examinations.

GPs demonstrated an understanding of Gillick competency(used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge). Staff we spoke with were able to provide an example of applying this guideline in relation to a 14 year old patient who was competent to make decisions about their care and the patient's notes recorded that they were 'Gillick competent.'

The practice held a register of patients with dementia and annual health checks were offered to patients on the register. Patients with dementia were supported to make treatment decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The practice had previously identified 14 patients with dementia who were on the register. The practice recognised that this was a low number of patients and had held meetings and all GPs had undertaken additional dementia awareness training to improve the diagnosis of this condition. As a result of the training the register had increased from 14 patients to 21 at the time of our inspection.

Health promotion and prevention

There was a range of health information available to patients in the waiting areas which included leaflets which could be taken away from the practice. Posters and displays promoted healthy living and patients we spoke with told us that the GPs and nurse routinely asked them about their broader health during appointments including exercise and diet. One patient told us that during an appointment with the practice nurse, the nurse suggested that the patient had a cholesterol test. The patient subsequently had a cholesterol test and the result of which were high. The patient felt that they were able to manage their high cholesterol at an early stage because of the nurse's attentive care.

It was not practice policy to offer all new patients registering with the practice a health check with the GP or practice nurse. New patients were required to complete a health questionnaire as part of registering with the practice and health checks were offered to patients opportunistically. For example, prior to a prescription being generated, a new patient would be required to be seen by a GP and a health check would be performed during this appointment. The practice also offered health checks for patients aged 40 -75 opportunistically. We noted a culture amongst the staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice performance for cervical screening uptake was below the local CCG target and to address this issue the practice had planned to utilise the practice nurses to offer patients appointments during extended hours. The GPs offered family planning advice, prescribed oral contraceptives, post-coital contraceptives and provided contraceptive injections.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice was performing well for childhood immunisations and had administered seasonal flu vaccinations to 69% of the eligible patient population registered with the practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Patients with drug and alcohol issues were referred to local drug and alcohol services and information was displayed in the patient waiting room signposting patients to these services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014. We spoke with ten patients during our inspection including two members of the PPG and we received 18 Care Quality Commission (CQC) comment cards completed by patients to provide us with feedback on the practice.

The evidence from all these sources showed that the majority of patients were satisfied with their GP practice. The vast majority of the comment card we received were complimentary about the level of care received by patients from the practice. Results of the national patient survey showed that 84% of patients described their overall experience of the practice as good which was above the local CCG average of 79%. The national survey also showed that 81% of patients found that the last GP they saw or spoke to was good at treating them with care and concern.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Patients also told us that if a member of staff needed to come into the GPs room during a consultation, they always knocked the door and waited for the GP to respond before entering the room.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice reception was situated behind a screen partition and the waiting area was located away from the reception desk. Staff gave us examples of how they ensure patient privacy was maintained which included avoiding discussions with patients about the reason for their appointment at the reception desk, using patient record numbers as opposed to patient names in discussions with colleagues and keeping their voices low when speaking to patients. The practice had corridors adjacent to the reception desk and away from the waiting area which staff told us could be utilised if a patient wished to have a private discussion with a member of the reception team and this would prevent patients overhearing potentially private conversations.

From the comment cards we received, patients stated that they felt the practice offered a good service and both clinical and administrative staff were helpful and caring. They said staff treated them with dignity and respect. The results of the national patient survey showed that 83% of patients found the receptionists at the surgery to be helpful. We also spoke with ten patients on the day of our inspection and they told us that their dignity and privacy was respected. During our inspection we observed reception staff interacting with patients in a respectful and caring manner. We noted one elderly patient experiencing difficulties in the reception and observed that a member of the reception team came out from reception, spoke to the patient in her own language and assisted her to a seat in the waiting area. The staff member also assisted the patient and escorted her to her appointment when it was due.

Care planning and involvement in decisions about care and treatment

The results of the national patient survey 2014 showed that 91% of patients reported that the last GP they saw or spoke to was good at listening to them which was above the CCG average of 87%. Seventy percent of patients felt that the last GP they saw or spoke to was good at involving them in decisions about their care which was below the CCG average of 76%. However, during our inspection patients we spoke with said the GPs involved them in decisions about their care and treatments and this was also reflected in the CQC comment cards we received. One patient told us that when diagnosed with a serious condition, the GP spent a long time explaining the nature of the condition including using diagrams They discussed several different care options and the GP arranged for the patient to be referred to two different specialists before they decided on the type of surgery.

The vast majority of patients we spoke with during our inspection told us that they didn't feel rushed during their appointment and this was also reflected in the results of the national patient survey whereby 83% of patients reported that the last GP they saw or spoke with was good at giving them enough time.

Good

Are services caring?

A telephone interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care. We saw notices in the waiting area informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection were positive about the emotional support provided by staff at the practice and this was reflected in the CQC comment cards we received. Staff told us that if families had suffered a bereavement, their usual GP contacted them. During our inspection we spoke with two patients who had experienced a bereavement and received emotional support from the practice. One patient whose husband had passed away recently told us that her GP telephoned her immediately upon hearing the news that her husband had passed away and subsequently telephoned daily for the first week to check on her well-being. The GP attended the funeral and gave the patient details of bereavement support services and a local widows' support group. The patient was also told by her GP that the practice would endeavour to accommodate appointment times for her at the end of surgery so that there would not be any time pressures for her consultation.

One patient told us that after being diagnosed with a serious medical condition and getting ready for surgery, the GP gave attention to patient's mental well-being. The practice also referred patients to the Improving Access To Psychological Therapies (IAPT) service for treatment of depression or anxiety disorders.

All staff had completed carer awareness training to identify carers registered with the practice and ensure that they were referred appropriately to the local authority for a Carers Assessment. Posters in the waiting area and information on the practice website also instructed patients who were carers to complete a form at reception so that they could be added to the carers list and the practice would endeavour to be flexible with appointment times to accommodate their commitments.

The notice board in the waiting area also provided patients with information on how to access a number of support groups and organisations such as Dementia Care. This organisation provides specialist support and advice to people with dementia and other neurological disorders and help carers through training, practical care support and specialised respite care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The patients we spoke with and those who completed comments cards felt the practice met their healthcare needs and were happy with the service provided.

The practice used a risk profiling software which enabled GPs to identify a range of at-risk patients and detect and prevent unwanted outcomes for patients. The GPs attended multi-disciplinary group meetings every three months with external professionals to discuss the care of patients including those at risk of unplanned admissions and A&E attendances.

There had been very little turnover of GPs over the last few years which enabled good continuity of care and accessibility to appointments with a GP of choice. The results of the national patient survey showed that 67% of respondents with a preferred GP usually got to see or speak to that GP, which was above the local CCG average of 51%.

We spoke with staff about vulnerable patient groups and what measures the practice had taken to engage with these groups and ensure that services were accessible. The practice registered homeless individuals, those in temporary accommodation and those with temporary residence in the United Kingdom. Staff told us that the practice also provided Food Bank vouchers for people in need.

To meet the needs of the working age and student population, the practice provided two extended hours clinics for appointments during the week in the evenings and early morning appointments before 9am. Telephone consultations were also offered to patients where appropriate.

In the waiting area we observed that there was seating available with arm rests which catered for patients who may have difficulties in sitting and standing, such as those with musculoskeletal conditions.

The practice clinical staff included two male and two female GPs and patients we spoke with told us that they could make an appointment with either a male or female GP if they wanted to.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG's work had contributed to the improvement of services and they told us it had improved communication between patients and the practice. For example, the PPG requested that the practice notice board was re-organised, tidied and included dedicated areas such as information for carers and this had been implemented.

Tackling inequity and promoting equality

Staff told us that the practice served a population of mixed ethnicities. Some staff members were able to speak additional languages to English including Gujarati and Hindi. There was an automated check-in screen available for patients to use with several languages relevant to the local community.

The practice could cater for different languages through the use of a telephone translation and interpreting service. We saw evidence of the provision of the translation service for patients on practice noticeboard. The practice however, did not have a hearing loop system available to assist patients with reduced ranges of hearing.

Staff we spoke with confirmed that they had not completed equality and diversity training but were able to describe various forms of discrimination.

The practice provided GP services for homeless persons who were able to register with the practice using the practice address. Letters for these patients were sent to the practice and patients would be contacted by mobile telephone to inform them that post was received for their collection.

The premises and services were adapted to meet the needs of people with disabilities. For example, the consultation rooms were situated on the ground floor and disabled toilets were available with raised toilet seats for ease of use.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and accessible toilet facilities were available for all patients attending the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice opening hours were between 8:00am-8:00pm Monday and Tuesday and 8.00am-6.30pm Wednesday-Friday. Telephone access was available during core hours and home visits were provided for patients who were housebound or too ill to visit the practice. Patients could book appointments by telephone, in person and online. Appointments were generally ten minutes in length however longer appointments were also available for people who needed them, for example, patients with long term conditions, learning disabilities and older patients.

Telephone access was available during core hours and patients were triaged for appointments. For urgent appointments patients were triaged and seen on the same day. The appointment system had availability for urgent appointments each day. Patients we spoke with and the comment cards we received, confirmed that they could see a doctor on the same day if they needed to.

The vast majority of patients we spoke with during our inspection told us that they were satisfied with the opening hours of the practice. The results of the national patient survey which was completed by 129 patients, found that 68% were satisfied with the opening hours which was below the local CCG average of 74 %.

To cater for the needs of the working age and student patient population the practice used a messaging service which sent patients appointment reminders via text message to mobile telephones. Repeat prescriptions could be requested in person or via email and were available for collection within three working days. We observed posters within the waiting area which gave patients information regarding the repeat prescription service.

Information was available to patients about appointments on the practice website and there was also information for patients on how to access urgent medical assistance when the practice was closed. If patients telephoned the practice when it was closed, an answerphone message gave information on the out-of-hours service.

The practice monitored the appointment system and needs of the patients by monitoring the 'Did Not Attend' (DNA) appointment rate. Members of the PPG told us that the DNA rate was also discussed at the PPG meetings.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who managed all non-clinical complaints and the GPs managed the clinical complaints in the practice.

We saw that the complaints procedure was displayed on posters in the waiting area and there was a complaints leaflet to help patients understand the complaints system. During our inspection we observed that a patient had arrived very late for an appointment and complained that he was not being seen. We observed that the reception staff were professional and advised the patient of the complaints procedure and promptly gave the patient a complaints form.

We looked at the five complaints received during the last 12 months and found that these were satisfactorily handled and responses to patients provided in a timely way. We looked at the complaint summary report for the last year and themes identified included blood tests, staff attitude and timeliness of a diagnosis. In response to a complaint regarding the waiting time for a blood test, the practice arranged for more appointment slots to be made available for blood tests and an extra clinic so that the waiting times were cut. Lessons learned and actions taken in response to the complaints received were documented and we saw practice meeting minutes to evidence complaints being discussed and shared with staff. At the time of our inspection, the practice had no outstanding complaints being dealt with.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide a comprehensive service with an emphasis on preventative medicine, maintenance of good health, treating patients promptly when they became ill and supporting patients with their long term health. We spoke with a cross section of staff and they told us the practice aims included providing the best quality care for patients. We found details of the vision on the practice website.

During our inspection we were provided with evidence of the practice's business plan which had been developed in September 2014 and was to be reviewed during 2015 which included a strategy for the future development of the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared drive of any computer within the practice and as hard copies within a policy folder. All of the six policies and procedures we looked at had been reviewed and were up to date.

We spoke with four members of staff and they were all clear about their own roles and responsibilities. Although there was no formal leadership structure document developed by the practice in place, staff we spoke with were able to identify named members of staff in lead roles such as safeguarding. Staff told us they felt well supported, there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The overall QOF score for this practice for 2013/14 showed it had achieved 659.33 out of 876 QOF points which was 17.8% below the local CCG average and 18.7% below the England average.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Leadership, openness and transparency

The practice had a programme for meetings. Whole administration team meetings were held every three months, management and clinical meetings were held weekly and multidisciplinary meetings were attended by clinical staff every three months. We found that meeting minutes were recorded in a hard copy book and not all of these were recorded electronically and stored on the computer shared drive. Some of the clinical meeting minutes we reviewed did not have an agenda and dates for follow up.

We spoke with four members of staff who told us that they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. Policies and procedures such as absence and sickness and bullying and harassment were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on training and appraisals. Staff we spoke with knew where to find these policies if required.

The practice also had a whistleblowing policy and staff we spoke with were aware of the policy if they wished to raise any concerns and were able to describe circumstances in which they would use it.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, the Friends and Family Test (a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care) suggestions, and complaints received. The practice website requested that patient complaints and suggestions as to how the practice could improve the service were to be put in writing and addressed to the practice manager. We looked at the results of the national patient survey which showed that 45% of patients reported they usually waited 15 minutes or less after their appointment time to be seen which was below the local CCG average of 50%. In response to this feedback and suggestions from the PPG, the practice arranged for patients to be kept informed by reception staff if a GP was running late and also to be informed when checking in.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG) of approximately 10-12 members. The PPG met every two months and was attended by a GP and the practice manager. During our inspection we met with two PPG members who informed us that the group drafted their own agendas for the meetings. Agenda items discussed included the appointment system, the layout of notice boards and the lighting outside the practice. The chairs of the PPGs within the area also met monthly to share best practice and invited members of the local CCG, MPs and service providers for discussions at their meetings.

Staff and members of the PPG we spoke to provided examples of other improvements that had been made to the practice as a result of patient feedback. For example, the PPG raised a safety issue relating to the lack of lighting outside of the practice. In response to this issue the practice organised more lighting on the pathways and the outside of the building to be arranged. We saw that actions taken by the practice following discussions raised by the PPG were posted on the practice website.

The practice had gathered feedback from staff through practice meetings and appraisals. Staff told us their managers were approachable and they felt comfortable to give feedback and discuss any concerns or issues. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

The practice had gathered feedback from staff through appraisals, staff meetings and informal discussions. Staff told us they were encouraged to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they were involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had completed reviews of significant events and other incidents and shared lessons learnt with staff via meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: People who use services were not fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out or recorded prior to a staff member taking up post. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.