Deanhill Surgery

Quality Report

Deanhill Surgery
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Date of inspection visit: 20 October 2014
Date of publication: 05/03/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Deanhill Surgery is a small sized GP practice based in Richmond. The practice provides primary care services to around 2050 patients.

We carried out an announced comprehensive inspection on 20 October 2014.

Overall the practice is rated as inadequate.

We found numerous issues in relation to the safety and there were inadequate systems in place to monitor and respond to risks. The extent of the issues identified indicated that there was a lack of managerial oversight. As a result, safe, effective and well-led were rated as inadequate. We rated effective and responsive as requires improvement and caring as good.

Due to inadequate ratings in safe,effective and well led .The concerns which led to these ratings apply to all population groups using the practice.

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

The leadership of the practice was inadequate. There was no clear leadership structure and staff did not feel supported by management. The provider had two practices, which were registered separately with the Care Quality Commission. We were told that the same management team were responsible for the running of both practices, but they rarely attended Deanhill Surgery and policies and procedures had not been adapted to ensure they were relevant and fit for purpose.

The practice did not hold regular governance meetings and issues were discussed at ad-hoc meetings. Staff did not feel involved or engaged and learning from incidents or complaints was not disseminated to support improvement.

Safety was not sufficiently prioritised and there were inadequate systems in place to monitor and manage risks. Staff understood their responsibilities to raise concerns, and report incidents and near misses. However, when things went wrong, reviews and investigations were

Summary of findings

not sufficiently thorough. Not all staff demonstrated the necessary competencies in relation to safeguarding and the nurse had not undergone a criminal records check prior to commencing work. The practice was visibly unclean on the day of our inspection and there were insufficient systems in place to protect patients from the risk of infection.

Staff had knowledge of and reference to National Guidelines but there were no systems to ensure this was consistent. There were no completed audit cycles for patient outcomes. Multidisciplinary working was not taking place.

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Importantly, the provider must:

Ensure there are appropriate systems, governance arrangements and effective leadership in place to monitor the quality of the service being provided.

Ensure that all clinical staff have full Disclosure and Barring Checks and there is a clearly documented rationale for not undertaking a DBS check on other staff to demonstrate that any risks have been assessed.

The practice must ensure all staff are sufficiently competent in child protection and safeguarding vulnerable adults so they are able to identify and respond appropriately to potential concerns.

The practice must ensure they maintain appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity.

The practice must ensure that all clinical and administrative staff are properly trained, supervised and appraised.

In addition the provider should:

Ensure that clinical audit cycles are completed to demonstrate improved outcomes for patients. The practice should also work with other professionals and organisations involved in patients' care to ensure they receive care that is well co-ordinated and effective.

Actively seek to involve patients in developing and improving the service.

Ensure staff are engaged and involved in developing and improving the service and ensure that learning from incidents and complaints are disseminated.

Provide a practice website, and offer online repeat prescription and appointments booking to enable patients to have flexibility.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Although the practice reviewed when things went wrong, lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. Administrative staff had not undertaken safeguarding training and were not aware of the processes of reporting safeguarding concerns. No infection control audits were being undertaken. There were no systems in place to ensure the premises were cleaned appropriately. The practice nurse did not have a DBS check.

Are services effective?

Inadequate

The practice is rated as requires improvement for effective as there are areas where improvements need be made. Staff had knowledge of and reference to National Guidelines but there were no systems to ensure this was consistent. The practice had not completed full cycles of audits. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was not taking place. No staff at the practice had received any appraisals.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than other practices for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Information was provided in accessible formats to help patients understand the care available to them. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for responsive. Although the practice had reviewed the needs of their local population, it had not put a plan in place to secure service improvements for all of the areas identified such as the high need of benzodiazepines and other prescription medicines for people experiencing poor mental health. Accessible information was provided to help patients understand the complaints system. However, there was no evidence of shared learning from complaints with staff.

Summary of findings

Are services well-led?

Inadequate 

The practice is rated as inadequate for being well-led. Staff we spoke with were not clear about their leadership and management responsibilities. There was no clear leadership structure and staff did not feel supported by management. The practice had a number of policies and procedures to govern activity; however these were produced over four years ago and had never been reviewed. The practice did not hold regular governance meetings and issues were discussed at ad-hoc meetings. The practice did not have a Patient Participation Group (PPG). Staff told us they had not received regular performance reviews and did not have clear organisational objectives.

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

Inadequate

The provider was rated as Inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The care of older people was not managed in a holistic way. The leadership of the practice have little understanding of the needs of older people and were not attempting to improve the service for them. Services for older people were therefore reactive, and there was a limited attempt to engage this patient group to improve the service.

People with long term conditions

Inadequate

The provider was rated as Inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Very few of these patients had a named GP and personalised care plan. Structured annual reviews were not undertaken to check that patients' health and care needs were being met. Multi-disciplinary team meetings were not held to support and review care of patients.

Families, children and young people

Inadequate

The provider was rated as Inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk. There was no evidence of joint working with other health and social care services to ensure families, children and young people received multidisciplinary care.

Immunisation rates were also relatively low for a number of the standard childhood immunisations.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as Inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The age profile of patients at the practice was mainly those of working age, students and the recently retired but the services

Summary of findings

available did not reflect the needs of this group. Appointments could only be booked by telephone and there were no early or extended opening hours for working people. There was a low uptake for both health checks and health screening.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as Inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice did not hold a register of patients living in vulnerable circumstances. It was unable to identify the percentage of patients who had received an annual health check. The practice had not worked with multi-disciplinary teams in the case management of vulnerable people. Reception staff did not how to recognise signs of abuse in vulnerable adults and children. They were not aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours or who the safeguarding lead at the practice was.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as Inadequate for safe,effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice was unable to identify patients experiencing poor mental health or those with dementia. It had not worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

Summary of findings

What people who use the service say

We received 12 completed comments cards and spoke with five patients. The majority of patients reported being happy with the care and treatment they received. However all patient's we spoke with mentioned the difficulties they had experienced when the practice had used several different Locum GPs.

Comments cards received had a common theme regarding the lack of online appointments and difficulties obtaining repeat prescriptions. Patients told us that the practice was not always clean.

The practice did not involve patients in developing and improving the service.

Areas for improvement

Action the service MUST take to improve

- Ensure there are appropriate systems, governance arrangements and effective leadership in place to monitor the quality of the service being provided.
- Ensure that all clinical staff have full Disclosure and Barring Checks and there is a clearly documented rationale for not undertaking a DBS check on other staff to demonstrate that any risks have been assessed.
- The practice must ensure all staff are sufficiently competent in child protection and safeguarding vulnerable adults so they are able to identify and respond appropriately to potential concerns.
- The practice must ensure they maintain appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity.
- The practice must ensure that all clinical and administrative staff are properly trained, supervised and appraised.

Action the service SHOULD take to improve

- Ensure that clinical audit cycles are completed to demonstrate improved outcomes for patients. The practice should also work with other professionals and organisations involved in patients' care to ensure they receive care that is well co-ordinated and effective.
- Actively seek to involve patients in developing and improving the service.
- Ensure staff are engaged and involved in developing and improving the service and ensure that learning from incidents and complaints are disseminated.

Provide a practice website, and offer online repeat prescription and appointments booking to enable patients to have flexibility.

Deanhill Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector a GP specialist advisor and a practice manager advisor.

Background to Deanhill Surgery

Deanhill Surgery is a small sized GP practice based in Richmond. The practice provides primary care services to around 2050 patients. The ethnicity of patients is mainly white British with small numbers of Asian and Black patients.

In the Borough of Richmond male life expectancy is 81.5 years and female life expectancy is 85 years. Both are above the England average for both males and females. An estimated 20,000 people in Richmond have a common mental disorder. Common mental disorders (such as depression and anxiety) are the most prevalent mental health conditions. About 50% of those with common mental health problems may require some form of treatment.

The practice is located in a purpose built building. The practice has two full time female locum GPs and one male locum GP working one day a week. The practice has no permanent salaried GPs. The principal GP is based at the main branch surgery and does not work from Deanhill Surgery. The practice has two reception staff and a practice manager based at another site. There was one practice nurse who provided 15 hours of care per week.

The practice holds a Personal Medical Services (PMS) contract for the delivery of general medical services.

Personal Medical Services (PMS) agreements are locally agreed contracts between NHS England and a GP practice. PMS contracts offer local flexibility compared to the nationally negotiated General Medical Services (GMS) contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).

The practice have opted out of providing out-of-hours services to their own patients. A local out of hours service, 111, is used to cover emergencies.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

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. 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.

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

• Working age people (including those recently retired and students)

• People living in vulnerable circumstances

• People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. The practice is on Band 1 of GP intelligent monitoring. The Bands range from 1-6, with 1 being a high priority for inspection. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey.

We carried out an announced visit on 20 October 2014. During our visit we spoke with a range of staff such as GPs, the practice manager, practice nurse and administrative staff, and spoke with patients who used the service. We observed how staff interacted with patients, carers and/or family members in a caring way. We received 12 completed patient comments cards.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used limited information to identify risks and improve quality in relation to patient safety. On the day of our inspection the practice was upgrading their computer system. Therefore we could not access or observe the processes used for significant events. The principal GP told us that adverse events were discussed as they happened. However the process was informal and the systems, processes and practices were not always reliable to keep people safe.

Learning and improvement from safety incidents

The practice had limited systems in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us .However the principal GP and the practice manager were the only staff involved in the discussion of these events. Reviews and investigations did not include all relevant people. There was no evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. The principal GP described an incident that had occurred when a patient had not been referred to secondary care following an abnormal blood result. The principal GP had identified learning points following this incident. However no formal systems had been set up to reduce future occurrence.

National patient safety alerts were disseminated by the practice manager to practice staff. The process was not formalised and we could not follow through examples of such alerts being sent to staff. However all clinical staff had individually signed up to receiving alerts that were role specific. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. For example the practice nurse had signed up to receiving alerts that were relevant to her role such as vaccinations and wound care.

Reliable safety systems and processes including safeguarding

The practice did not have systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that administrative staff had not received relevant role specific training on safeguarding children and adults.

We asked members of medical, nursing and administrative staff about their most recent training. All administrative staff could not tell us who the lead for safeguarding was at the practice. They had not yet received training and could not confirm when this was planned for. Another administrative member of staff who had been at the practice for 18 months had also not received training. They told us their role did not involve patient contact, but we noted that they covered the reception area duties in times of sickness and absence. Neither of the administrative staff could demonstrate they had an understanding of what safeguarding children and adults involved and what their role was in responding to any concerns.

Both Locum GPs at the practice had received Level 3 child protection training. The practice nurse had received Level 2 child protection training. Clinical staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details of the local safeguarding teams were easily accessible to clinical staff through display on notice boards in clinical rooms.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. We could not verify if any staff had undertaken Chaperone training due to lack of records being kept. However nursing staff understood the responsibilities when acting as chaperones but they told us they had never been required to act as one before. The nursing staff did not have a DBS check for the practice and no risk assessment was in place to mitigate the lack of a DBS.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records that confirmed the fridge temperatures were checked and recorded. All recordings for the past year were within the required range. Systems were in place to check medicines were within their expiry date and suitable for use. A check list was available and the practice nurse used this to ensure all checks were accurate. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Are services safe?

Vaccines were administered by the nurse using current directives that had been produced in line with legal requirements and national guidance. We saw a copy of directives from the Clinical Commissioning Group (CCG) and evidence that nurse had received appropriate training to administer vaccines. All vaccination batch numbers were recorded in the patient's record to ensure that if an alert was raised on the vaccine they could easily identify patients who had been affected.

There was a protocol for repeat prescribing which was in line with national guidance and was followed by the practice. Patients could request repeat prescriptions in writing. The practice did not offer online requests of prescriptions. 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. They were tracked through the practice, and kept securely at all times.

Cleanliness and infection control

We observed that the premises were not clean or tidy. There were no cleaning schedules in place and no cleaning records were kept. Staff told us that a cleaner attended the surgery a number of times per week. However they did not know the schedule that the cleaner followed. The practice had no appointed person who ensured the cleaner followed the cleaning schedule and checked the premises to ensure all the cleaning had been satisfactorily completed. Patients we spoke with told us the practice was not always clean and they had concerns about cleanliness and infection control.

No records were available on training about infection control for staff .The nurse told us they had received the training at a local hospital where they worked outside of the practice. There was no evidence of infection control audits being carried out at the practice in the last two years. All clinical and administrative did not know of any infection control audits being completed or the individual who would have completed them.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. However this had been last updated in 2010. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We observed that a toilet used by staff located on the first floor did not have a hand washing sink. Staff washed their hands in the kitchen sink.

When we spoke to the principal GP, they told us that the toilet room was too small to have a sink fitted in. The patient toilet located on the ground floor had a hand washing sink with hand washing gel and hand towels.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We could not confirm when this had been carried out as records could not be located and no Legionella risk assessment was available.

Equipment

We saw records and equipment maintenance logs that confirmed all equipment was regularly tested. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of February 2014. A schedule of testing was in place. We saw evidence of calibration of equipment such as weighing scales and the fridge thermometer. This had been completed in March 2014.

Staffing and recruitment

Records we looked at did not contain evidence to show that all appropriate recruitment checks had been undertaken prior to employment. For example, the practice nurse did not have a Disclosure and Barring Services (DBS) check that had been completed specifically for the practice The practice had used a DBS check completed for her by another employer that was more than five years old. No risk assessment was in place to mitigate the lack of a DBS. All other staff files kept by the practice did not contain proof of qualifications and registration with the appropriate professional body. However, all locum staff were able to provide us with their proof of qualifications and recent DBS checks they personally kept.

The practice had a high turnover of staff. Prior to the inspection the CCG had shared concerns regarding the high level of locum use at the practice. The principal GP told us that they had used a number of locum GPs in the last 18 months. The principal GP told us they had found it difficult to recruit permanent staff or to get other GPs to commit to the partnership .The receptionist had been at the practice for less than two weeks at the time of our inspection. Another part-time administrative staff was due to retire. Our discussions with staff informed us that the administrative staff found the reception area very demanding.

Inadequate

Are services safe?

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, and equipment. The practice also had a health and safety policy.

Arrangements to deal with emergencies and major incidents

We saw no records that confirmed all clinical and administrative staff had received training in basic life support. Emergency equipment was available including access to oxygen. No defibrillator was at the practice. No emergency risk assessment was available for inspection.

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

Staff were not able to explain the business continuity plan or where it was located. They all told us they would ring the practice manager should there be an emergency or the principal GP.

A fire risk assessment had been undertaken that included actions required for maintaining fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence. Ten patient records viewed showed that staff followed guidelines in care pathways. We observed that staff ensured they had the latest guidance and information through their own means. No meetings were held at the practice where this information was discussed.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

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

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

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The practice had an overall OQF score of 625 points out of 900 (lowest in CCG). The principal GP agreed that the practice was poorly performing.

The practice provided evidence of two clinical audits that had been undertaken in the last year. The first audit was a check of patients using benzodiazepines and other controlled drugs. This audit showed that the practice continued to have a high number of patients using these medicines. Another audit had been carried out to identify patients diagnosed with dementia. However there were no plans for a re-audit to show what improvements had been made and so both audits did not form the full cycle of audits.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. We were told that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used, However the QOF performance data did not support this. Staff told us that the IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. Due to the IT upgrade taking place on our inspection day, we were unable to confirm if all alerts had been acted on.

Effective staffing

Practice staffing included medical, nursing and administrative staff. We reviewed staff training records and saw that all staff were not up to date with attending mandatory courses such as annual basic life support. The practice employed two locum GPs. These GPs had completed the required training on their own but not as part of training provided by the practice. All GPs were up to date with their yearly continuing professional development requirements. Some had been revalidated in 2014 and others were due for revalidation in 2016. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). The practice had records supplied by the practice nurse that showed their registration with the Nursing and Midwifery Council (NMC) was current. No records of staff appraisals were available. Clinical and nursing staff all confirmed that they had not received appraisals in the last year.

Administrative staff told us that they supported each other if they had concerns about their work. They felt that they would feel more supported if the practice manager was based at the practice or had a senior administrative lead. Clinical staff were reluctant to share their views on the support structure of the practice.

Working with colleagues and other services

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The practice had employed an administrative member of staff

who was solely responsible for processing these onto the system. The GP reviewing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

There was no evidence that the practice held multidisciplinary team meetings to discuss the needs of complex patents, such as those receiving end of life care or children on the at risk register. Staff told us they had contact details of services such as district nurses, health visitors and the palliative care team and made contact with them as and when needed.

Information sharing

An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from the out of hours service and hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity was an issue, the practice had drawn up a policy to help staff, for example with making 'do not attempt resuscitation' orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GPs were informed of all health concerns detected as a result of the health check and these were followed-up in a timely manner. The practice offered patients some health promotion leaflets. These were displayed in the waiting rooms. Leaflets available included dietary advice and support groups for weight loss, travel information and vaccinations, chronic disease management for asthma, diabetes, epilepsy, and sexually transmitted diseases.

The practice's performance for cervical smear uptake was poor at 59% this was worse than others in the CCG average was 84%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. There was a named nurse responsible for following-up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was below average for the CCG. There was a clear policy for following up non-attenders by the named practice nurse and we saw record that this policy was being followed. However staff explained that parents were reluctant in immunising children in the area and a number of children registered at the practice belonged to the travelling community who were hard to reach.

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. Data from the 2014 national patient survey showed that 95% of patients were satisfied with how they were treated and described the overall experience of their GP surgery as fairly good or very good. The practice had scored well in this area as the local CCG rate was 85%.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 12 completed cards and the majority were positive about the service. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk, so patient confidentiality was maintained.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area.

Patients we spoke with on the day of our inspection told us that their health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

We saw notices in the patient waiting room that sign posted people to a number of support groups and organisations. The GPs also referred patients who had been identified as requiring support for counselling.

During patient registration the practice noted down details of carers. This was to ensure they were offered support and information relating to patient and carer support information. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The Clinical Commissioning Group (CCG) told us that the practice did not regularly engage with them and other practices to discuss local needs and service improvements. The principal GP explained the difficulties they experienced with staffing and prioritising these meetings. They planned to attend future meetings.

There had been very high turnover of staff during the last 18 months which might have had an effect on patients care, lack of continuity of care and accessibility of appointments with a GP of choice. Three patients we spoke with mentioned the high number of locum GPs they had previously seen. However they all reported that this had been improved recently with them seeing more regular locums. Longer appointments were available for people who needed them and those with long term conditions.

Information for those patients that had attended services such as; out of hours, accident and emergency and other hospitals was shared electronically. A system was in place that scanned these records onto individual patient records to ensure continuity of care. However we could not access this system on the day of our inspection due to a systems upgrade that was taking place. All staff we spoke with were aware of the system they used locally and the practice had a nominated individual who was responsible for scanning all the documents on to the system.

Tackling inequity and promoting equality

The practice had a high number of patients with mental health conditions living locally. The practice was a high prescriber of Benzodiazepines. (Benzodiazepines are sometimes prescribed for short periods to ease symptoms of anxiety, sleeping difficulty and also occasionally for other reasons). The principal GP told us that they were aware of the high need for these drugs.

Access to the service

Appointments were available from 08:00 am to 11:00 am and 3:30pm to 6:30pm pm on weekdays. No extended hours were offered at the practice.

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

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice was situated on the ground floor and therefore easily accessible to patients.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice mainly had English speaking patients, but staff told us they were able to cater for other different languages through translation services.

The practice did not have online services to book appointments or for patients to request prescriptions. Patients we spoke with felt that this would be a useful facility for them to access.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system set out in the practice patient leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. However the practice did not have systems set up to review complaints to detect themes

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

or trends. Staff were aware of the complaints received. No staff meetings were held at the practice so learning from complaints was on an individual basis and was not formalised.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. This was clearly displayed in the patient waiting area and included in the practice patient leaflet. However administrative staff we spoke with were not aware of the vision and were not able to tell us how they contributed to the values. All clinical staff had individual vision of delivering high quality care to their patients. This was more on an individual basis rather than as part of the organisations' values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at six of these policies and procedures and staff had completed a cover sheet to confirm they had read the policy. The majority of policies and procedures we looked at had not been reviewed since 2010. We noted that the policies had been drafted for Richmond Green surgery (a nearby practice run by the same provider) and had not been adopted for "Deanhill surgery".

We found no evidence that the practice held governance meetings. The principal GP told us that these meetings were held at Richmond Green surgery and were informal. Staff at the practice told us that meetings were held at Richmond Green surgery but they did not attend these due to workload.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was not meeting the national standards. The principal GP was aware of this. The practice had an overall OQF score of 625 points out of 900 (lowest in CCG). They agreed that the practice was poorly performing. However they felt the practice did well in other areas that were not measured under the Quality Outcomes Framework. The practice nurse told us about a local peer review system they took part in with neighbouring GP practices.

The practice had not conducted full clinical audit cycles. The principal GP had information relating to medicines and dementia audits that they had completed. These were not formally written up. They explained that they had audited records and re-called patients for medication reviews. However this had not been formally completed and did not complete the audit cycle.

There was no evidence that the practice had arrangements for identifying, recording and managing risks. We saw no records of risk assessments that had been completed. The practice manager was not available for our inspection. No staff were aware of any risk logs being completed.

Leadership, openness and transparency

The practice staff were aware of the leadership structure. However this was for the whole organisation and mainly Richmond Green surgery. Staff told us that the practice manager was the main point of contact but was based at Richmond Green surgery. The practice manager attended the practice a few times per month according to both clinical and administrative staff. There was no deputy manager or nominated person of authority to deal with practice issues.

Clinical staff we spoke with were reluctant to express their views on how they were supported. The clinical staff all seemed to get support from colleagues and not from the practice. Administrative staff told us that they supported each other but felt that they would benefit from additional support if the practice manager was based at the practice. No practice meeting minutes were available. All staff confirmed that meetings were held at Richmond Green practice and none of them attended.

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

The practice did not have a patient participation group (PPG). The principal GP told us that they had never had a PPG due to a "funding technicality".

The practice had gathered feedback from patients through a paper based survey completed in May 2014.The purpose of the survey was to gather patient views on the phlebotomy services offered at the practice .Out of 60 patients, forty four patients (73%) received phlebotomy services at the practice and were able to give feedback on this service; they had found the use of in house phlebotomy useful.

We did not find any evidence that the practice had sought the views of their staff.

Are services well-led?

Inadequate

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

Management lead through learning and improvement

Staff told us they maintained their clinical professional development through training they undertook independently of the practice. No records of staff appraisals were available in respect of long standing staff members.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision How the regulation was not being met: The registered person did not have systems in place to ensure that adequate governance and monitoring systems were in place. No nominated person was on site to ensure the smooth operation of the service. No systems were in place to ensure staff were supported through appropriate supervision, staff meetings and appraisal. No regular governance meetings were taking place. There were no systems to ensure learning through significant analysis was taking place and was shared with staff. No recruitment polices were in place to ensure that where relevant staff employed in the practice had Disclosure and Barring Checks completed before commencing employment . No systems were in place to ensure premises were cleaned appropriately. No systems were in place to ensure administrative staff had adequate safeguarding training and sufficient knowledge to enable them to identify abuse to protect people using the service.