Westfield Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Westfield Medical Centre on 23 August 2017. Overall the practice is rated as requires improvement.

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

- There was a system in place for reporting and recording significant events. However, we did not see evidence that these were routinely discussed at monthly clinical meetings, and we were told these were not routinely shared with non-clinical staff.
- The practice had a number of systems to minimise risks to patient safety but these were not always effective. For example, the practice had access to a defibrillator which was located in the same building. The practice did not have oversight of this and could not assure themselves that should it be required in an emergency, it would be in good working order. The practice did not keep medications which could be used to treat severe pain or sickness and did not have a risk assessment in place to support this decision.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Patients we spoke with on the day agreed with the results from the national GP patient survey which showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks. The practice could not provide references to show satisfactory evidence of conduct in previous employment for two members of staff.
- Patient satisfaction regarding consultations with nursing staff was particularly high. For example, 100% of patients stated that they had confidence and trust in the last nurse they saw or spoke to.

Summary of findings

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- We did not see evidence that quality improvement activity was driving improvements to patient outcomes.
- There was a clear leadership structure and staff felt supported by management. The practice had a patient participation group which met regularly.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- Regular clinical meetings were held and documented. However, minutes were not taken at the nurse meetings and a documented record of what was discussed was not available.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

The areas where the provider must make improvements are:

- The provider must establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

In addition the provider should:

- Review the practice of not documenting appraisals for non-clinical staff and be able to evidence the discussions, development and training needs of the staff.
- Improve the documentation of all clinical meetings to ensure that all staff are aware of the discussions which have taken place and to enable the ongoing review of issues, concerns and events.
- Assure themselves that the level of safeguarding training for all staff including GPs is appropriate.
- Improve the identification of carers and maintain a register to enable this group of patients to access the care and support they require.
- Review their system for discussing significant events and complaints and be able to assure themselves that these are reviewed at regular intervals and shared with the staff team.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, we did not see evidence that these were routinely discussed at monthly clinical meetings or shared with non-clinical staff.
- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, a defibrillator was located in the same building as the practice however; the practice did not have oversight of this and could not assure themselves that should it be required in an emergency, that it would be in good working order.
- We reviewed the personnel files of three staff and found that the practice could not evidence references for two of these staff.
- Staff demonstrated that they understood their responsibilities in relation to safeguarding children and vulnerable adults. Most staff had received training relevant to their role, with the exception of one GP who was not trained to the appropriate level.
- We observed the premises to be clean and tidy and there were some monitoring systems in place. However, we were not assured that these systems were embedded as the privacy curtains required replacement in line with National Patient safety guidance and the sharps bins we saw were not dated or labelled.
- The practice did not maintain an oversight of the cleaning of the environment.
- It was noted that some patients who were on a register for patients who were taking disease-modifying antirheumatic drugs (DMARDs - drugs which act on the immune system to slow the progression of rheumatoid arthritis) were no longer taking these medicines.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were comparable when compared to the national average.
- Staff were aware of current evidence based guidance.

Summary of findings

- There was no evidence that quality improvement activity was driving improvements in patient outcomes.
- Staff had the skills and knowledge to deliver effective care and treatment.
- We saw a list of appraisal dates for clinical staff but we did not see evidence of appraisals and personal development plans for all staff. We were told that staff support was an ongoing process and the staff we spoke with on the day confirmed this.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.
- Services were provided to support the needs of the practice population, such as screening and vaccination programmes, health promotion and preventative care.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care including all aspects of nursing care.
- Survey information we reviewed showed that patients said they were treated with dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible. The practice had adopted the accessible information standards
- On the day of inspection patients told us they were treated with kindness and respect, and patient and information confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. The provider had introduced a new telephone triage service which had increased the number of patients they were able to assist in one session from 12 to 35.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they did not always find it easy to make an appointment with a named GP. However, we were told and saw evidence that urgent appointments and telephone consultations were available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from ten examples reviewed showed the practice responded quickly to issues raised and offered apologies to patients when necessary.
- The team had recently recruited staff including a new part time nurse. However, there were no nursing appointments offered to patients during the week of our inspection.

Are services well-led?

Requires improvement

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a leadership structure and staff told us they felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings. We saw examples of additional policies to protect and enhance the safety of the staff including a 'bomb threat, suspicious package and raid on the building' policy.
- We were shown some evidence of appraisals for clinical staff; we did not see evidence of appraisals for non-clinical staff.
- The practice had systems for being aware of notifiable safety incidents and these were shared with relevant staff and managed appropriately. However, we did not see evidence that these were routinely discussed at meetings.
- The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. We were told staff training was a priority and saw that this was built into staff rotas.
- We were told that a regular nurse meeting was held but that these meetings were not documented.
- We were not assured that the provider maintained an oversight of safe systems and processes at the practice.
- On the day of inspection we did not see any evidence of quality improvement activity or two cycle audits which would review the effectiveness and appropriateness of the care provided.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

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

- The practice was responsive to the needs of older patients; all patients over 75 were offered either an appointment or a telephone review on the day it was requested.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- Where older patients had complex needs, the practice shared summary care records with local care services, for example with out of hours services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. Annual health reviews were also offered.

People with long term conditions

Requires improvement

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

- We were told that nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice had a higher than average number of patients who were identified as diabetic: 10% of the practice population compared to 7% nationally.
- Outcome for patients with diabetes varied. The number of patients on the diabetes register who had a record of a foot examination was 89% which was the same as the national average. These figures related to the previous provider.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health. The practice offered drop in clinics for patients with long term conditions.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their

Summary of findings

health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice worked closely with its sister practice in Bradford which was a training centre for delivering diplomas in many long term conditions.

Families, children and young people

Requires improvement

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

- We saw examples where 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 accident and emergency (A&E) attendances or non-attendance at appointments.
- The immunisation rates related to the previous provider and were average for immunisations given to two year olds. However, they were 18% below the government standard for those given to five year olds at 72%.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications. All children under one year were guaranteed a same day appointment.

Working age people (including those recently retired and students)

Requires improvement

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours included both early morning and evening appointments.

Summary of findings

- The practice was proactive in offering online services including the electronic booking of appointments, telephone triage and the management of query's via a task to the clinician.
- Health promotion advice was accessible and health promotion material was available throughout the practice.
- Travel health advice and vaccinations were available.

People whose circumstances may make them vulnerable

Requires improvement

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice told us that they would take additional steps to ensure that vulnerable patients including refugees were assisted to register.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice worked with members of the multidisciplinary team including specialist nurses to achieve this.
- The practice offered longer appointments for patients with a learning disability, those whose first language was not English and patients with mental health issues.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

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

- The practice hosted an outreach clinic once or twice a month where a multi-lingual counsellor was available.

Summary of findings

- The practice specifically considered the physical health needs of patients with poor mental health and dementia and an annual health assessment was offered. The team also liaised with the community mental health team and worked with other health professionals including a psychologist and a pharmacist to meet the needs of this patient group.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The data below relates to the previous provider: 81% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to Clinical Commissioning Group (CCG) and national averages.
- The number of patients on lithium therapy (a widely used and studied medication for treating bipolar disorder) who had their levels recorded as within the therapeutic range was 100% compared with the CCG average of 89% and the national average of 90%.
- However data also showed that only 21% of patients newly diagnosed with depression in the preceding March to April had been reviewed at the appropriate interval. This was more than 60% less than the CCG and national averages.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Locality working with six other practices had enabled the practice to secure funding for access to a wellbeing co-ordinator who undertook social prescribing and was able to assist patients with benefits, isolation issues and referrals to support organisations.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017 and related to the current provider. The results showed the practice was performing in line with local and national averages. Data showed that 381 survey forms were distributed and 85 were returned. This represented 2% of the practice's patient list.

- 87% of patients described the overall experience of this GP practice as good which was the same as the CCG average and comparable to the national average of 85%.
- 78% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 82% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards of which nine were positive about the standard of care received. One patient commented that they did not like being asked about their problems over the phone, but overall they were happy with the service. Another patient commented that requests for medication and queries had been ignored.

We spoke with five patients during the inspection, three of whom the practice asked to come and speak to us. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring but occasionally the clinics ran late. We were approached by an ex-patient during the day of our inspection who said they had left the practice as they were very unhappy with the care and treatment given.

The Friends and Family test is a feedback tool which asks people if they would recommend the services they have used to their friends and family. Results collated by the practice from December 2016 to August 2017 showed that 85% of patients would be likely or extremely likely to recommend the surgery to their friends and family.

Areas for improvement

Action the service MUST take to improve

- The provider must establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Review the practice of not documenting appraisals for non-clinical staff and be able to evidence the discussions, development and training needs of the staff.
- Improve the documentation of all clinical meetings to ensure that all staff are aware of the discussions which have taken place and to enable the ongoing review of issues, concerns and events.
- Assure themselves that the level of safeguarding training for all staff including GPs is appropriate.
- Improve the identification of carers and maintain a register to enable this group of patients to access the care and support they require.
- Review their system for discussing significant events and complaints and be able to assure themselves that these are reviewed at regular intervals and shared with the staff team.

Westfield Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Westfield Medical Centre

Westfield Medical Centre provides services for 3,827 patients and is situated on the first floor of The Reginald Centre, 263 Chapeltown Road, Leeds, LS7 3EX West Yorkshire. There are fully accessible facilities and services are reached via stairs or a lift. There is car parking available and the centre is accessible by bus. The surgery is situated within a large health centre which also hosts other community services including a pharmacy, a library and a café.

Westfield Medical Centre is situated within the Leeds North Clinical Commissioning group (CCG) and provides primary medical services under the terms of a personal medical services (PMS) contract. This is a contract between general practices and primary care organisations for delivering services to the local community.

They offer a range of enhanced services such as the learning disabilities health check scheme.

There is a higher than average number of patients aged between birth and 34 years when compared to the national average. Only 8% of the practice population is aged 65 years and over compared to the national average of 17% and the CCG average of 16%.

The National General Practice Profile states that 27% of the practice population is from an Asian background with a further 26% of the population originating from a black ethnic background. 10% of the practice population are from mixed or non-white ethnic groups.

The new provider registered with the Care Quality Commission in March 2017; however they had been responsible for the provision of services for a period of time before this. We worked with them during that time to ensure they were appropriately registered. There was some continuation of staffing from the previous provider which included a small number of admin staff and a nurse.

There are two GP partners, (one of which is female) and a business partner. We were told the male GP partner does not often work at the practice. The practice is also staffed by two female salaried GPs, one part time practice nurse, a health care assistant (HCA), and an apprentice HCA, all of whom are female. The practice is also supported by a pharmacist from the CCG.

The clinical team are supported by a business manager, an office manager and a team of administrative staff.

We were unable to speak with the office manager or a practice nurse on the day of inspection.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

Westfield Medical Centre reception is open between 8.00am and 6pm Monday to Friday and appointments were available from 8.30am to 6pm daily at this location. Extended hours access was available every Tuesday between 6.30pm and 7.30pm, one Wednesday morning per month between 7am and 8am and one Saturday morning per month between 10.15am and 12.15pm.

Detailed findings

Out of Hours, patients are advised of the NHS 111 service.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including Leeds North Clinical Commissioning Group and NHS England to share what they knew. We reviewed policies, procedures and other relevant information the practice provided both before and during the inspection. We also reviewed the latest available data from the Quality and Outcomes Framework (QOF), national GP patient survey data, and the NHS friends and family test (FFT). QOF data related to the previous provider.

We carried out an announced visit on 23 August 2017. During our visit we:

- Spoke with a range of staff including two GPs, the registered manager and the business manager, an apprentice healthcare assistant and members of the reception and admin team.
- Spoke with five patients who used the service.
- Observed how patients were being cared for in the reception area.
- Met with one member of the Patient Participation Group.
- Reviewed 11 comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of 10 documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, and we saw evidence of an apology being offered.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings. However, we did not see evidence that these were routinely discussed at monthly clinical meetings. A GP told us on the day of inspection that they were not routinely shared with non-clinical staff.

Overview of safety systems and processes

Although risks to patients were assessed, the systems to address these risks were not always implemented well enough to ensure patients were kept safe.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. We were told that the lead GP attended safeguarding and multi-agency review meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. We saw that two GPs were trained to child protection or child safeguarding level three; however the practice could not evidence level three training for one GP.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We reviewed three personnel files and found appropriate recruitment checks had not been undertaken prior to employment, in line with the practice recruitment policy. For example proof of references could not be evidenced for two members of staff.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy and there were cleaning schedules in place for clinical equipment. However, we were not assured that systems were embedded as the privacy curtains were dated October 2016 and required replacement in line with National Patient safety guidance and the sharps bins we saw were not dated or labelled.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

On the day of inspection we saw that the arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- The practice held a stock of medications which could be used in an emergency. However, they did not keep medications which could be used to treat severe pain or sickness and did not have a risk assessment in place for this decision.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. The lead GP told us that they completed a quarterly review of antibiotic use for the CCG. We did not see evidence that there was a plan in place to reduce the high rates of

prescribing of these medications. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately. (A Patient Specific Direction (PSD) is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.)

- We saw that some patients who were on a register for patients who were taking disease-modifying antirheumatic drugs (DMARDs - drugs which act on the immune system to slow the progression of rheumatoid arthritis) were no longer taking these medicines.

Monitoring risks to patients

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

- There was a basic health and safety policy available.
- The practice had an up to date fire risk assessment and had carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had other risk assessments to monitor safety of the premises such as legionella (Legionella is a bacterium which can contaminate water systems in buildings).
- General cleaning of the building was undertaken by an external contractor. The practice could not provide a risk assessment for the control of substances hazardous to health (COSHH) as they told us they did not have access to the cleaning cupboards. The office manager attended a building representatives meeting where general cleaning standards were agreed as acceptable.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The practice had recently recruited additional GP cover and a further part time practice nurse.

Arrangements to deal with emergencies and major incidents

On the day of inspection, the practice could not assure themselves that they had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in a treatment room, however not all the recommended medications were in place and we did not see a risk assessment for this decision.
- The emergency medicines were easily accessible to staff in a secure area of the practice. On the day of inspection one member of the admin team could not locate the medicines when asked. All the medicines we checked were in date and stored securely.
- A defibrillator was located in the same building as the practice however; the practice did not have oversight of this and could not assure themselves that should it be required in an emergency that it would be in good working order. Following our inspection the practice acquired a defibrillator for their own use and sent us evidence that it had been checked on that day.
- There was access to oxygen with adult and children's masks. A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 92% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%. These results related to the previous provider. Unverified data for 2016/ 2017 showed that the practice had achieved 97% of the total number of points available.

Overall exception reporting was 6% which is lower than the CCG and national averages of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice had mixed results in relation to some patient outcomes. Data from 2015/2016 showed:

- Overall performance for diabetes related indicators was lower than CCG and national averages. However 97% of patients with diabetes, on the register, had received an influenza vaccination in the preceding 1 August to 31 March compared with the CCG average of 96% and the national average of 95%.
- Overall performance for mental health related indicators was lower than CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a record of alcohol consumption in the last 12 months was 83% compared to the CCG average of 87% and the national average of 89%.
- Data also showed that only 21% of patients newly diagnosed with depression in the preceding March to April had been reviewed at the appropriate interval. This was more than 60% less than the CCG and national averages. When we discussed these results with the practice, they were not aware of them or of why this figure was so low.
- The number of patients on lithium therapy (a widely used and studied medication for treating bipolar disorder) who had their levels recorded as within the therapeutic range was 100% compared with the CCG average of 89% and the national average of 90%.

On the day of inspection we did not see evidence of quality improvement activity or clinical audits.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. One afternoon a month was used to support training and development of staff, in addition to other training programmes.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- We saw some evidence of appraisals for clinical staff. On the day of inspection we did not see evidence of appraisals or personal development plans for non-clinical staff. We were told that staff support was an ongoing process and the staff we spoke with on the day confirmed this.

Good

Are services effective?

(for example, treatment is effective)

- Staff told us that they had access to appropriate training to meet their learning needs and to cover the scope of their work which included ongoing ad hoc support.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

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

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- Locality working with six other practices had enabled the practice to secure funding for access to a wellbeing co-ordinator who undertook social prescribing and was able to assist patients with benefits, isolation issues and referrals to support organisations.

The practice's uptake for the cervical screening programme was 84%, which was comparable with the CCG average of 82% and the national average of 81%.

Uptake for bowel screening within six months of invitation was 48% which was lower than the CCG average of 60% and the national average of 58%. Breast screening rates were also lower than average, 63% of females aged 50-70 had undergone screening compared to the CCG and national average of 73%. However, we were told that the practice was taking pro-active steps including contacting non-attenders to encourage patients to attend these screening programmes. All of these results related to the previous provider.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to two year olds were 91% which is comparable to the government recommended standard of 90%. The percentage of five year olds who had their immunisations was 73%. This was below the recommended standard. The practice were aware of this and were working to engage parents whose first language was not English and transient patients who moved between services. These results also related to the previous provider.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening

Good

Are services effective?

(for example, treatment is effective)

test. For all patients they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for patients aged 40–74 and additional checks for patients aged over 75. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Currently all three GPs working at the practice are female; however, when we spoke to patients they did not feel this was an issue.

Of the 11 patient Care Quality Commission comment cards we received, nine were positive about the service experienced. Patients said they felt the practice offered a good service and staff were respectful. One patient acknowledged that the practice was clean and tidy but felt that their queries had not been followed up by the practice and a further patient said that they would prefer to be given a time for telephone consultations.

We spoke with five patients and one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff were caring and treated people as individuals.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice showed comparable satisfaction scores for consultations with GPs; however satisfaction regarding consultations with nursing staff was particularly high. For example:

- 89% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 88% of patients said the GP gave them enough time which was the same as the CCG average and comparable to the national average of 86%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 86%.
- 99% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) and national average of 91%.
- 96% of patients said the nurse gave them enough time compared with the CCG and national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG and national average of 97%.
- 99% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared with the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Children and young people were treated in an age-appropriate way and recognised as individuals. The practice ran clinics for young people where they could attend without an appointment.

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

- 86% of patients said the last GP they saw was good at explaining tests and treatments which was the same as the national average and comparable to the CCG average of 87%.

Good

Are services caring?

- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 98% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 94% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

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

- Staff told us that interpretation 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. Longer appointments were available for these patients.
- Information leaflets were available in easy read format.
- The NHS e-Referral service (previously known as choose and book) was used with patients as appropriate.

Patient and carer support to cope emotionally with care and treatment

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services and the practice proactively signposted patients to the Wellbeing co-ordinator.
- The practice told us that they had a carers register; however we saw that there was only one person identified as a carer. The practice recognised that whilst they had been coding people who told them they had a carer, they had not done the same for people who were carers. The practice identified this as a priority moving forward.
- However, we saw that information was available to direct carers to the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered extended hours every Tuesday evening between 6.30pm and 7.30pm. An early morning surgery was held once a month on a Wednesday from 7am and on a Saturday between 10.15am and 12.15pm once per month, for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability, those whose first language was not English and for patients who had additional needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. Telephone triage appointments were also available.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS.
- There were accessible facilities, which included a low reception desk, a hearing loop, accessible toilets and lifts.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services, including the registration of vulnerable patients such as refugees.
- The practice had considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients received information in formats that they could understand and received appropriate support to help them to communicate. A message on the computer screen would alert the clinician if a patient required additional support.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 6pm. Extended hours access was available every Tuesday between 6.30pm and 7.30pm, one Wednesday morning per month between 7am and 8am and one Saturday morning per month between 10.15am and 12.15pm.

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

- 81% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 77% and the national average of 71%.
- 87% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 86% and the national average of 84%.
- 82% of patients said their last appointment was convenient compared with the CCG average of 83% and the national average of 81%.
- 78% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 79% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 61% and the national average of 58%.

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

The practice had a system to assess:

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

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Its 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 and that a leaflet was available.

We looked at 10 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and that explanations and apologies were given where necessary. We did not see that these were routinely discussed with staff in an attempt to raise awareness or share any lessons learned.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- There was a statement of purpose submitted to the Care Quality Commission which identified the practice values. For example, to provide high quality services to patients in safe and appropriate surroundings.

Governance arrangements

The practice had a governance framework to support the delivery of the strategy and good quality care. We saw that these arrangements were not always effective and we were not assured that the provider maintained an oversight of safe systems and processes at the practice.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas for example safeguarding.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly. We saw examples of additional policies to protect and enhance the safety of the staff including a 'bomb threat, suspicious package and raid on the building' policy.
- An understanding of the performance of the practice was maintained. However, we did not see evidence that regular practice meetings provided an opportunity for staff to learn about the performance of the practice.
- On the day of inspection we did not see any evidence of quality improvement activity or two cycle audits which would review the effectiveness and appropriateness of the care provided.
- There were arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence of two significant events being discussed at a full team meeting in March 2017. However, we did not see evidence that these or any complaints were routinely discussed at meetings. We were told that nurse meetings were held regularly but these were not documented.

Leadership and culture

The lead GP told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. From the sample of 10 documented complaints we reviewed: we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- We did not see evidence that the practice kept written records of verbal interactions as well as written correspondence.

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with the exception of the nurse meetings.
- GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings and we saw evidence of this.
- We did not see evidence of appraisals for non-clinical staff. The management had decided to discontinue formal appraisals and had made staff aware of this in a meeting in July 2017. We were told on the day of inspection by the registered manager and the non-clinical staff that regular discussions were held and staff were given opportunities to develop their skills. We noted that one of the appraisals evidenced to us for clinical staff was not undertaken by the practice but was for the purpose of GP revalidation.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.

Are services well-led?

Requires improvement

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

- Staff said they felt respected, valued and supported, particularly by the partners in the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice told us that it valued feedback from patients and staff. It sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and had recently met with the business partner for the practice and had discussed plans to meet with patients in the reception area to ascertain their views.
- the NHS Friends and Family test, complaints and compliments received
- staff through staff meetings and ad hoc discussions.
- staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was part of local pilot schemes to improve outcomes for patients in the area.

The practice discussed plans with us as part of the locality working, to introduce new services for patients in the coming year including a vasectomy and dermatology services.

The GP partner was a trainer for GPs and the practice had recently been confirmed as a teaching practice. A GP registrar was to join the practice from February 2018, and medical students were expected to join the surgery form the end of 2017.

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 17 HSCA (RA) Regulations 2014 Good governance Systems and processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance. **How the regulation was not being met:** The registered person had systems and processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The provider could not assure themselves that there was an effective system in place to ensure the defibrillator was checked regularly and in good working order, should it be required in an emergency. • The provider could not assure themselves that the systems in place for the recruitment of staff were operating effectively, and included all necessary employment checks for all staff. • The provider could not evidence quality improvement activity and did not routinely review the effectiveness and appropriateness of the care provided in order to provide safe, effective care. • The provider did not maintain an effective system to oversee infection prevention and control issues. They had not ensured that privacy curtains were replaced in line with National Patient safety guidance and sharps bins were not dated or labelled. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.