Dr BS Jassal's Practice (Brunel Medical Centre)

Quality Report

Brunel University
Uxbridge
UB8 3PH
Tel: 01895 234426
Website: www.sites.brunel.ac.uk/medicalcentre

Date of inspection visit: 22/09/2016
Date of publication: This is auto-populated when the report is published

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 7

What people who use the service say 11

Areas for improvement 11

Detailed findings from this inspection

Our inspection team 13

Background to Dr BS Jassal's Practice (Brunel Medical Centre) 13

Why we carried out this inspection 13

How we carried out this inspection 13

Detailed findings 15

Action we have told the provider to take 25

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr B S Jassal's Practice (Brunel Medical Centre) on 22 September 2016. This was to follow up a comprehensive inspection we carried out on 23 April 2015, during which a breach of a legal requirement set out in the Health and Social Care Act (HCSA) 2008 was found: Regulation 11 HCSA 2008 (Regulated Activities) Regulations 2014 Need for Consent and Regulation 12 HCSA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. Overall the practice was rated as requires improvement (you can read the previous report by selecting the 'all reports' link for Dr B S Jassal's Practice (Brunel Medical Centre) on our website at www.cqc.org.uk).

After the inspection the practice drew up an action plan to improve its performance in response to the findings of the previous inspection. At the follow up inspection we reviewed the practice's progress in implementing this plan. Although the practice had made improvements in some areas there were still outstanding concerns from our previous inspection and overall the practice remains rated as requires improvement.

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

- There was a system in place to report and record significant events and patient safety alerts. However, the practice could not demonstrate how learning was shared practice-wide.
- Although risks to patients were assessed and managed, we found outstanding actions from our previous inspection regarding recruitment checks and mandatory training.
- Non-clinical staff had not been appraised within the last 12 months.
- The practice had processes in place to keep patients safe and safeguarded from abuse and we saw improvement since our previous inspection for clinical

Summary of findings

training to an appropriate level. However, not all non-clinical staff had undertaken safeguarding children training relevant to their role and none had undertaken vulnerable adult training.
- There was evidence of clinical audit being carried out, but there was no evidence that a quality improvement programme, including clinical audit, was in place.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

The areas where the provider must make improvements are:

- Ensure recruitment procedures include all necessary employment checks for staff, including locum staff and risk assess whether non-clinical staff require DBS checks.
- Carry out staff appraisals and provide structured opportunities for staff to review their performance with their manager.
- Ensure all staff have completed the mandatory training identified, specifically safeguarding, infection control, fire awareness and information governance.
- Ensure there is an effective system for sharing learning outcomes from significant events and alerts practice-wide.
- Ensure all key policies and procedures are kept up-to-date.
- Develop an ongoing quality improvement programme, including clinical audit, that demonstrates continuous improvement to patient care.
- Formulate a written strategy to deliver the practice's vision.

In addition the provider should:

- Ensure there is a failsafe process in place to ensure patients receiving high risk medicines are reviewed and managed appropriately.
- Ensure there is a system in place to track blank prescriptions through the practice in line with national guidance.
- Ensure basic life support training includes the use of a defibrillator and staff know the location of the recently procured oxygen, that there are adult and child masks available, it is regularly checked on a schedule with other emergency equipment and a suitable warning sign is placed on the door where it is located. Ensure all panic buttons are accessible to staff in the event of an emergency.
- Continue to encourage the uptake of cervical smear screening.
- Advertise translation services in the waiting room and consider having health-related leaflets available in other languages.
- Continue to review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Provide a meeting forum for non-clinical staff to meet, raise any issues and receive practice feedback.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- There was a system in place to report and record significant events and patient safety alerts. However, the practice could not demonstrate how learning outcomes were shared practice-wide.
- Although risks to patients were assessed and managed, we found outstanding actions from our previous inspection. For example, staff files were inconsistently maintained and the practice could not demonstrate permanent staff and locum staff had been safely and effectively recruited and there were gaps in mandatory training which included safeguarding, infection control, fire and information governance.
- The practice had processes in place to keep patients safe and safeguarded from abuse and we saw improvement since our previous inspection for clinical training to an appropriate level. However, not all non-clinical staff had undertaken safeguarding children training relevant to their role and none had undertaken vulnerable adult training.

Are services effective?

Requires improvement

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

- Non-clinical staff had not been appraised within the last 12 months.
- There were gaps in mandatory training, which included safeguarding, fire awareness, infection control and information governance.
- There was evidence of clinical audit being carried out, but there was no evidence that a quality improvement programme, including clinical audit, was in place.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally comparable to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice broadly in the line with local and national averages. However, the response rate was only 0.3% and may not be representative of the practice's population. For example, 71% of patients said the GP was good at listening to them (CCG average 83%; national average 89%) and 96% of patients said they had confidence and trust in the last GP (CCG average of 92%; national average 95%).
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. This was echoed in the national GP patient survey where 76% of patients usually got to see or speak to their preferred GP (CCG average 55%; national average 59%).
- The practice had good facilities and was well equipped to treat patients and meet their needs and provided, in addition to pre-bookable appointments, a daily doctor-led student walk-in clinic and nurse-led sexual health clinic. Extended hours were provided three evenings and one morning per week.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

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

- The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. However, there was no formal written strategy or supporting business plan to achieve it.

Summary of findings

- Although there was a leadership structure in place, the practice could not demonstrate an effective overarching governance framework to support improvements in the delivery of good care. Furthermore, the practice had not fully implemented the improvements identified during the previous inspection.
- The practice had a number of policies and procedures to govern activity, but some of these were overdue a review.
- Although the practice held a weekly clinical meeting there was no meeting forum for non-clinical staff. The practice could not demonstrate an effective system for sharing information and learning outcomes practice-wide.
- The practice did not have a Patient Participation Group (PPG). This was an outstanding finding of our previous inspection. The practice told us they were actively trying to recruit members and we saw information on its website.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.

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, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there was evidence of some good practice.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice had a dedicated primary care navigator who liaised with Age Concern UK to support patients to maintain independence and signpost them to local services.
- The practice accessed the CCG integrated care programme (ICP) developed to enable adults over the age of 65 who have one or more long-term health conditions, including those who may feel isolated, to live healthy, fulfilling and independent lives.
- The practice was responsive to the needs of older people which included annual health reviews, home visits and urgent appointments for those with enhanced needs when required.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there was evidence of some good practice.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The prevalence of long-term conditions rates for coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD) and diabetes was low but this could be explained by the specific characteristics of its younger population of which 80% were students.
- Performance for diabetes-related indicators was lower than the national average for all indicators except influenza immunisation. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less was 66% (national average 78%), the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is

Summary of findings

5 mmol/l or less was 66% (national average 81%) and the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 69% (national average 88%).

- All these patients had a named GP and a structured annual review to check their 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 which included referral to structured educational programmes.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there was evidence of some good practice.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were comparable to local and national averages for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 45% which was below the CCG average of 78% and the national average of 82%. We saw evidence that the practice were proactive in encouraging uptake through poster campaign and information on the practice website. The practice told us they opportunistically offered screening at walk-in clinics.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there was evidence of some good practice.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered a daily doctor-led student walk-in clinic and a nurse-led sexual health clinic.

Summary of findings

- Extended hours are provided on Tuesday, 6.30pm to 8pm, Wednesday 6.30pm to 8pm and Thursday 7am to 8am and 6.30pm to 7.30pm.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. For example, chlamydia screening.
- The practice works closely with the university counselling service and disability and dyslexia support service.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there was evidence of some good practice.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients and informed vulnerable patients about how to access various support groups and voluntary organisations.
- Although staff knew how to recognise signs of abuse in vulnerable adults and children not all non-clinical staff had undertaken safeguarding raining and none had undertaken vulnerable adult training.
- The practice hosted a fortnightly walk-in drug and alcohol clinic.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there was evidence of some good practice.

- Performance for mental health related indicators was comparable to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 100% (national average 88%) and the percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 71% (national average 84%).

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. Three hundred and seventy-one survey forms were distributed but only 32 were returned. This was a response rate of only 0.3% and may not be representative of the practice's population. Overall the results were broadly in line with local and national averages. However, results were above local and national average for access. For example,

- 84% of patients found it easy to get through to this practice by phone compared to the CCG average of 69% and the national average of 73%.
- 76% of patients usually got to see or speak to their preferred GP compared to the CCG average of 55% and the national average of 59%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and the national average of 76%.
- 67% 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 70% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 44 comment cards, of which 39 were positive, three were mixed and two were negative. The positive comments included good care, friendly staff and an efficient service. The negative comments included waiting time to be seen for an appointment and feeling a doctor had not listened well.

We spoke with 19 patients during the inspection, all of whom were satisfied with the care they received and thought staff were approachable, committed and caring.

The practice shared the results of the Friends and Family Test (FFT) results for February and March 2016 which showed 91% of patients would be extremely likely or likely to recommend the practice to a friend or family member. The practice posted results of the FFT on its website.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment procedures include all necessary employment checks for staff, including locum staff and risk assess whether non-clinical staff require DBS checks.
- Carry out staff appraisals and provide structured opportunities for staff to review their performance with their manager.
- Ensure all staff have completed the mandatory training identified, specifically safeguarding, infection control, fire awareness and information governance.
- Ensure there is an effective system for sharing learning outcomes from significant events and alerts practice-wide.
- Ensure all key policies and procedures are kept up-to-date.
- Develop an ongoing quality improvement programme, including clinical audit, that demonstrates continuous improvement to patient care.
- Formulate a written strategy to deliver the practice's vision.

Action the service SHOULD take to improve

- Ensure there is a failsafe process in place to ensure patients receiving high risk medicines are reviewed and managed appropriately.
- Ensure there is a system in place to track blank prescriptions through the practice in line with national guidance.

Summary of findings

- Ensure basic life support training includes the use of a defibrillator and staff know the location of the recently procured oxygen, that there are adult and child masks available, it is regularly checked on a schedule with other emergency equipment and a suitable warning sign is placed on the door where it is located. Ensure all panic buttons are accessible to staff in the event of an emergency.
- Continue to encourage the uptake of cervical smear screening.
- Advertise translation services in the waiting room and consider having health-related leaflets available in other languages.
- Continue to review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Provide a meeting forum for non-clinical staff to meet, raise any issues and receive practice feedback.

Dr BS Jassal's Practice (Brunel 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 an Expert by Experience.

Background to Dr BS Jassal's Practice (Brunel Medical Centre)

Dr BS Jassal's Practice (Brunel Medical Centre) is located on the campus of Brunel University. The practice provides NHS primary medical services through a General Medical Services (GMS) contract (a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract) to around 10,300 patients, around 80% of whom are students. The annual turnover of patients joining and leaving the practice is high with around 2,000 students registering each year. At the time of our inspection the practice was in the middle of its registration process for the commencement of the new academic year.

The practice operates from a two-storey university-owned medical centre with access to three consulting rooms on the ground floor and two consulting rooms on the first floor. The first floor is accessed by stairs. The building is maintained by the university facilities management team.

The practice has a much larger than average proportion of young adults on its patient list, particularly in the age ranges 15-19, 20-24 and 25-29. The practice has a low proportion of patients over the age of 75 years (1.4% of its practice population).

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

The current practice staff team comprises two female and one male GP partners (totally 24 sessions) and one term-time female regular locum GP (five sessions), a full-time practice nurse and healthcare assistant, a practice manager and a team of reception and administrative staff.

The practice is open from 8:30am to 6:30pm Monday to Friday. Extended hours are provided on Tuesday, 6.30pm to 8pm, Wednesday 6.30pm to 8pm and Thursday 7am to 8am and 6.30pm to 7.30pm.

The practice provides a range of services including childhood immunisations, chronic disease management, sexual health, cervical smears and travel advice and immunisations.

When the practice is closed, patients are directed to a local out-of-hours service. The practice also provides information about local emergency services on its website and practice leaflet.

Detailed findings

Why we carried out this inspection

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

The inspection was carried out to follow up a comprehensive inspection undertaken on 23 April 2015 when we rated the practice overall as requires improvement. Specifically we found the practice required improvement in providing safe and effective care. In particular the practice was found to be in breach of Regulation 11 of the Health and Social Care Act Need for Consent and Regulation 12 of the Health and Social Care Act Safe Care and Treatment.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 September 2016. During our visit we:

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

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The practice told us they had a system of reporting significant events in a weekly clinical meeting which was attended by the doctors, practice nurse and practice manager. The practice shared nine significant events from the last 12 months. It was difficult to assess if the incident form consistently 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) as each significant event was recorded in a different format. We did see that events recorded included a description of the event, what went well, what could have been done better and learning outcomes. However, it was difficult to track how they had been shared as minutes of clinical meetings available were written in an agenda-style with bullet points and did not always include who had attended. Furthermore, the practice could not demonstrate how learning outcomes were shared practice-wide. We reviewed one patient-related significant event regarding a delayed diagnosis and saw evidence that the patient had been seen and received an apology.

The practice told us all patient safety alerts were received by the practice manager and the doctors and acted upon if relevant. One of the GPs discussed some recently received safety alerts including one regarding risk of death from failure to prioritise home visits in general practice and how the practice had dealt with it. However, the practice could not provide an audit trail of alerts received, how they were actioned or evidence of how they were shared practice-wide.

Overview of safety systems and processes

The practice had processes in place to keep patients safe and safeguarded from abuse, which included:

- The practice had policies in place for safeguarding children and adults which reflected relevant legislation and local requirements and outlined who to contact for further guidance if staff had concerns about a patient's welfare. However, both policies were overdue a review from March 2016. The GPs told us they attended safeguarding meetings when possible and always provided reports where necessary for other agencies. There was a lead member of staff for safeguarding. One member of staff we spoke with was unsure who the safeguarding lead was. The GPs, practice nurse and healthcare assistant were trained to safeguarding level 3. This was an improvement from the findings of our previous inspection when only two of the GPs had been trained to level 2, which was below the level of competency appropriate for their role. Only five of the nine non-clinical staff had received safeguarding children training relevant to their role. However, all staff we spoke with understood their responsibilities to raise safeguarding concerns and were aware of an alert system on the computer which identified vulnerable children and adults. The GPs, practice nurse and healthcare assistant had received training on safeguarding adults. The practice nurse had also undertaken Female Genital Mutilation (FGM) awareness training. None of the non-clinical staff had undertaken safeguarding adult training which had been a finding from our previous inspection. The internal safeguarding adults policy indicated non-clinical staff would be trained to a level appropriate to their role.
- A notice in the waiting room and consultation rooms advised patients that chaperones were available if required. Only the practice nurse and healthcare assistant acted as a chaperone and 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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the GPs was the infection control clinical lead supported by the practice nurse who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and a separate policy for handling sharps and specimens. At the time of our inspection only the GP lead, practice nurse and healthcare assistant had undertaken up-to-date training. This was an outstanding finding from our previous inspection. All staff we spoke with on the day knew the location of the bodily fluid spill kits and had access to appropriate personal protective equipment when handling specimens at the reception desk.
- An internal infection control audits had been undertaken in September 2016 and we saw evidence that action was taken to address any improvements

identified as a result. For example, identification of staff members not having up-to-date training. After the inspection the practice advised us that on-line training had been arranged and sent evidence that four out of nine non-clinical staff had completed it to date.

- Arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Procedures were in place for handling repeat prescriptions but these did not include a failsafe process to ensure patients receiving high risk medicines were reviewed as appropriate. For example, we found some patients had been prescribed warfarin (a drug which reduces the risk of blood clots forming) without checking the International Normalised Ratio (INR). INR testing is an integral part of warfarin treatment and its measurement and interpretation of the result guides the dosage of warfarin. The practice utilised prescribing optimisation software which interfaced with the practice's clinical system to ensure safe and appropriate prescribing. Blank prescription pads were securely stored and logged. However, there was no system in place to log and track printer prescriptions through the practice. 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). These were signed by the practice nurse and lead prescriber. The healthcare assistant had been trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).
- We reviewed four personnel files including a locum doctor file. The practice could not provide any recruitment check paperwork for the locum doctor. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). The permanent staff files were inconsistently maintained and had shortfalls in information to demonstrate staff had been safely and effectively recruited and employed. For example a member of staff recruited since our last inspection did not have references or proof identification. Inconsistency in the recruitment evidence recorded by the practice was a finding from our previous inspection. The practice had not undertaken any DBS checks on non-clinical staff and did not have a clear rationale or risk assessment to support this decision. The practice shared with us a recruitment and selection policy and locum recruitment check list protocol which would be used for all subsequent recruitment. The recruitment and selection policy referenced obtaining references and pre-employment checks but did not specifically refer to DBS checks.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety.

- The practice premises were owned and maintained by the university who undertook scheduled checks but not all documentation was available on the day of the inspection. For example, risk assessments relating to health and safety, fire and Control of Substances Hazardous to Health (COSHH). There was a health and safety policy available with a poster in the staff kitchen which identified the local health and safety representative. After the inspection the practice sent evidence that they had undertaken a health and safety and COSHH risk assessment.
- There was a fire procedure in place and we saw evidence that all fire extinguishers and the fire alarm were maintained. Fire evacuation drills were undertaken regularly and we saw a log of these. All staff we spoke with on the day knew where the fire evacuation assembly point was located and were aware of the procedures in the event of a fire. The practice had identified a GP partner as the nominated fire marshal but at the time of our inspection they had not undertaken any fire awareness or marshal training. This was an outstanding finding from our previous inspection. After the inspection the practice sent evidence that all staff except five had undertaken on-line fire awareness training.
- Each clinical room was appropriately equipped. We saw evidence that the equipment was maintained. This included checks of electrical equipment and equipment

used for patient examinations. We saw evidence that calibration of equipment used by staff had been undertaken in January 2016 and portable electrical appliances had been checked in April 2016.

- A Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) risk assessment had been undertaken by the landlord and regular water temperature checks as part of the maintenance of the premises.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice used locum doctors when required. There was a locum pack available.

Arrangements to deal with emergencies and major incidents

The practice 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 an emergency. Consulting rooms were also installed with a panic alarm system linked to the university's security team. However, due to the configuration of some of the consulting rooms the panic button was situated in an inaccessible location.
- All staff received annual basic life support training but this did not include training in the use of the AED (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).
- At our previous inspection in April 2015 it was noted that the practice did not have access to oxygen although an AED was available. The practice was advised to have oxygen available or carry out a risk assessment to show why this was not necessary in the practice. The practice had carried out a risk assessment and concluded that oxygen would not be held on the practice premises due to their assessment that the ambulance service would be able to respond to an emergency within eight minutes. After the inspection the practice provided evidence that an oxygen cylinder had been ordered.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. The practice had a pharmacy on-site which opened to correspond with the practice's opening times which included extended hours. A first aid kit was available in the nurse's room and an accident book was available on reception. Staff we spoke with knew the location of these.
- The practice did not have a business continuity plan on the day of the inspection but produced one after the inspection. This included plans in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 87% of the total number of points available.

This practice was an outlier in terms of its low prevalence rates for coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD) and diabetes but this could be explained by the specific characteristics of its younger population with 80% of its patients being students. Data from 2014/15 showed:

- Performance for diabetes-related indicators was lower than the national average for all indicators except influenza immunisation. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less was 66% (national average 78%), the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 66% (national average 81%) and the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 69% (national average 88%). The practice had a low prevalence of diabetes at 1% (national average 6%).
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90 mmHG or less was 77% which was comparable with the national average of 84%.
- Performance for mental health related indicators comparable to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 100% (national average 88%) and the percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 71% (national average 84%).

There was evidence of clinical audit being carried out, but there was no evidence that a quality improvement programme, including clinical audit, was in place.

- There had been two clinical audits completed in the last two years both of which were two-cycle audit where the improvements made were implemented.
- Findings were used by the practice to improve services. For example, the practice reviewed all its type two diabetic patients taking aspirin for primary prevention of cardiovascular disease in line with NICE guidance. The first cycle audit undertaken in August 2015 revealed 95 patients had type two diabetes, of which 34 were taking aspirin for primary prevention with no previous cardiovascular event. All patients were reviewed and medication changes made. A repeat audit in January 2016 revealed 11 patients to be on aspirin with no clear indication in the medical notes supporting the prescribing of aspirin. A re-review of all 11 patients was undertaken.

Effective staffing

Although staff had the skills, knowledge and experience to deliver effective care and treatment we found the schedule of annual appraisal and mandatory training had lapsed.

- The practice had an induction programme for all newly appointed staff. This covered such topics as fire safety, health and safety and confidentiality.
- None of the non-clinical staff had had an appraisal since 2014. The healthcare assistant told us she had had an appraisal with the practice nurse within the last 12 months. The practice nurse had been supported by one

Requires improvement

Are services effective?

(for example, treatment is effective)

of the GPs through the Nursing and Midwifery Council (NMC) revalidation process using the Royal College of Nursing-accredited e-portfolio appraisal framework. However, they had not received a practice-based appraisal in the last 12 months.

- Not all staff had received mandatory training as identified by the practice. For example, safeguarding, infection control, fire awareness and information governance.
- We saw evidence of role-specific training and updating for relevant staff. For example, those reviewing patients with long-term conditions had undertaken update training in asthma and diabetes and those 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. The practice was a yellow fever vaccine centre and we saw evidence of up-to-date training and registration.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice used an IT interface system (GP2GP) which enables patients' electronic health records to be transferred directly and securely between GP practices. This improves patient care as GPs will usually have full and detailed medical records available to them for a new patient's first consultation.

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

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 practice had put in place a written consent form for patient procedures including insertion and removal of sub-dermal implants. This had been a finding of our previous inspection and we saw evidence that this had now been implemented.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation were signposted to the relevant service.
- The practice accessed the CCG integrated care programme (ICP) developed to enable adults over the age of 65 who have one or more long-term health conditions, including those who may feel isolated, to live healthy, fulfilling and independent lives.
- The practice had a dedicated primary care navigator who liaised with Age Concern to support patients to maintain independence and signpost them to local services.
- The practice utilised the CCG's Rapid Response Service (a single point of contact for adult patients experiencing a health crisis who could be safely cared for in the community instead of being admitted to hospital).

The practice's uptake for the cervical screening programme was 45% which was significantly below the CCG average of

Requires improvement

Are services effective?

(for example, treatment is effective)

78% and the national average of 82%. This finding had decreased from our previous inspection where 2013/14 QOF data showed the practice's uptake for the cervical screening programme was 51% (national average 80%). The practice opportunistically offered screening at daily walk-in clinics and we saw evidence of poster and information on the website encouraging patients to attend for screening.

Childhood immunisation rates for the vaccinations were generally in line with CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 67% to 89% and five year olds from 68% to 97%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

Of the 44 patient Care Quality Commission comment cards received, 39 were positive about the service experienced. Patients said they felt the practice offered good care, with friendly staff and an efficient service. Three of the comment cards were mixed and two were negative which related to the waiting time to be seen for an appointment.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was broadly in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. However, the response rate for the survey was only 0.3% and may not be representative of the practice's population. The practice had not reviewed the data prior to our inspection. For example:

- 71% of patients said the GP was good at listening to them compared to the CCG average of 83% and the national average of 89%.
- 63% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 95%.
- 57% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 78% and the national average of 85%.
- 82% of patients said the nurse was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 91%.
- 87% of patients said the nurse gave them enough time compared to the CCG average of 89% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 95% and the national average of 97%.
- 82% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 64% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and the national average of 86%.
- 67% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and the national average of 82%.
- 87% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 90%.
- 70% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 85%.

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

Good

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. However we did not see any notices in the reception area and there were no information leaflets available in any other languages.
- Several members of the practice staff spoke other languages, for example Urdu and Punjabi.
- One member of staff was trained in sign language.
- Information screens ran educational and health-related topics in the waiting room.

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 including counselling and disability and dyslexia support services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 12 patients as carers (0.2% the practice list). Written information was available to direct carers to the various avenues of support available to them. The practice also referred carers to the primary care navigator for further guidance and support.

Staff told us that if families had suffered bereavement, their usual GP contacted them and sent them a sympathy card. This was either followed by a patient consultation at a flexible time and location to meet the family's needs 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 reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example,

- The practice offered extended hours on Tuesday, 6.30pm to 8pm, Wednesday 6.30pm to 8pm and Thursday 7am to 8am and 6.30pm to 7.30pm.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities and translation services available. However, the practice did not have a hearing loop. After the inspection the practice sent evidence that a hearing loop had been purchased.

Access to the service

The practice is open from 8:30am to 6:30pm Monday to Friday. Appointments were from 9am to 11am and 4.30pm to 6pm. In addition, the practice offers a daily doctor-led student walk-in clinic 11.30am to 1.15pm and a nurse-led sexual health clinic from 11.30am to 1.15pm. Extended hours are provided on Tuesday, 6.30pm to 8pm, Wednesday 6.30pm to 8pm and Thursday 7am to 8am and 6.30pm to 7.30pm.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above local and national averages for some outcomes. For example:

- 84% of patients found it easy to get through to this practice by phone compared to the CCG average of 69% and the national average of 73%.
- 76% of patients usually get to see or speak to their preferred GP compared to the CCG average of 55% and the national average of 59%.
- 93% of patients said the last appointment they got was convenient compared to the CCG average of 89% and the national average of 92%.
- 67% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and the national average of 76%.

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

The practice had a system in place to assess:

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

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 an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- 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. For example, posters in the waiting room and information in the patient leaflet and on the practice's website.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Lessons were learnt from individual concerns and complaints. The practice could not demonstrate how it shared outcomes and learning practice-wide. The practice did not have non-clinical staff meetings.

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 told us they had a vision to deliver high quality care and promote good outcomes for patients. However, there was no formal written strategy or supporting business plan to achieve it.

Governance arrangements

The practice could not effectively demonstrate an overarching governance framework to support improvements in the delivery of good quality care:

- The practice had not fully implemented the improvements identified during the previous inspection.
- There were insufficient systems in place for monitoring staff recruitment to ensure that all of the appropriate checks to keep people safe had been carried out.
- The practice did not have an effective system in place for the organisation of mandatory training and staff appraisal.
- Some practice specific policies were not up to date and were in need of a review.
- There was evidence of clinical audit being carried out, but there was no evidence that a quality improvement programme including clinical audit was in place.

Leadership and culture

On the day of inspection the partners in the practice told us they prioritised safe, high quality and compassionate care. However, we found outstanding concerns from our previous inspection relating to areas of the management of the practice. These related to recruitment, staff appraisal and mandatory training.

Staff told us the partners were approachable and always took the time to listen to all members of staff. The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment the affected people reasonable support, truthful information and a verbal and written apology.

There was a leadership structure in place and staff felt supported by management. However, since the beginning of the year the previous practice manager has been absent and the assistant practice manager had been overseeing the practice management role single-handedly.

- Although the practice held weekly clinical meetings there was no forum for non-clinical staff to meet and the practice could not demonstrate an effective system for sharing outcomes of meetings practice-wide. Minutes of meetings were recorded in bullet-point format and did not always include who had attended.
- The practice attended external meetings which included the quarterly university student welfare group meetings and the monthly practice network meetings.
- Staff told us there was an open culture and said they felt respected, valued and supported by the partners.

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

- The practice did not have a Patient Participation Group (PPG). This was an outstanding finding of our previous inspection. The practice told us they were actively trying to recruit members and we saw this information on its website.
- The practice had gathered feedback from an internal patient survey undertaken in September 2016 as part of an initiative in its practice network. The practice had not reviewed the national GP patient survey from January or July 2016.
- 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 took part of local pilot schemes to improve outcomes for patients in the area. For example, the practice made use of a local primary care navigator (supporting patients in the high risk care group take an active role in supporting the management of their care and social needs and working towards self-care). The practice operated as part of a local network of four GP practices (Concorde Health).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not ensured that appropriate pre-employment checks were carried out to ensure the safe and effective recruitment of staff and locum staff. The provider did not operate effective systems to ensure staff received an appraisal. The provider had not ensured that non-clinical staff had received mandatory training. For example, safeguarding children and adults, fire safety, infection control and information governance. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not operate effective systems and governance arrangements that enabled them to identify, assess and mitigate risks to patients. Specifically: The provider could not demonstrate an effective system for sharing learning outcomes from significant events and alerts. The provider could not demonstrate that all key policies and procedures were kept up-to-date. The provider did not have an ongoing quality improvement programme, including clinical audit, that demonstrated continuous improvement to patient care.

This section is primarily information for the provider

Requirement notices

The provider did not have a written strategy to deliver the practice's vision.

The provider had failed to ensure that the concerns identified when we last inspected the service had been addressed. For example, recruitment checks and mandatory training.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.