Oxshott Medical Practice

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	Good
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?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Oxshott Medical Practice on 11 November 2014. We visited the practice location at Oxshott Medical Practice, Holtwood Road, Oxshott, Leatherhead, Surrey, KT22 0QJ 2014.

We have rated the practice as good although areas of improvement were required. The inspection team spoke with staff and patients and reviewed policies and procedures implemented throughout the practice. The practice was responsive to the needs of the local population and engaged effectively with other services.

Our key findings were as follows:

- There was a range of appointments to suit most patients' needs. Patients reported good access to the practice and a named GP or GP of choice, with urgent appointments available the same day.
- The practice engaged effectively with other services and agencies to ensure continuity of care for patients.
- Patient feedback showed that patients felt they were involved in making decisions about their care and were treated with kindness and respect.
- However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure there are clear arrangements in place for the management of obtaining, safe storage and handling of medicines.
- Ensure recruitment processes include all required pre-employment checks in order to minimise the risks to the health, safety and welfare of patients.
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the health, safety and welfare of patients and staff in respect of fire safety procedures and infection control.

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 safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example; there were no policies or procedures regarding medicines management. Staff recruitment practices were unsafe because the required criminal record checks via the Disclosure and Barring service had not been undertaken on all of the clinical staff. Fire safety procedures had not been tested as a fire drill had not been undertaken in the practice.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. Multidisciplinary working was evidenced.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical commissioning group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had considerable challenges in respect of the building environment and facilities. However, patients said their

Summary of findings

needs were met. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions and had attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services. For example all older patients had a named GP. Patients told us the practice was responsive to the needs of older patients, including offering home visits and same day appointments for those with enhanced needs. Older patients with complex care needs all had personalised care plans that were shared with other services to facilitate the continuity of care.

The practice had safeguarding processes to protect vulnerable patients from abuse. Staff were aware of the process and were able to describe what action to take if they suspected abuse or had concerns. A chaperone service was available to all patients.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. When needed, longer appointments and home visits were available. All of these patients had a named GP and structured annual reviews to check whether their health and medicine 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. Appropriate monitoring and reviews were undertaken to support patients with managing their conditions and preventing deterioration in their health.

The practice had safeguarding procedures in place to protect vulnerable patients from abuse. Staff were aware of this and were able to describe what action to take if they suspected abuse or had concerns.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments were available outside of school hours and the practice ensured that children needing an urgent appointment would be seen the same day. The premises were suitable for children because there were toys and books to

Summary of findings

keep them occupied whilst waiting for their appointment. There was evidence of good communication and collaboration between the practice and other agencies including midwives, child and adolescent mental health services and other support organisations.

The practice had safeguarding procedures in place to protect children from abuse. Staff were aware of this and were able to describe what action to take if they suspected abuse or had concerns.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The practice had made some adjustments to the services it offered to ensure these were accessible, flexible and offered continuity of care. A telephone message service to answer queries and questions had been introduced. Late evening appointments were available to patients on one evening per week. The practice offered online appointment booking and prescription services to meet the needs of this group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. For example, those with learning disabilities. The practice held a register of patients living in vulnerable circumstances, including those with learning disabilities and mental health problems. Annual health checks were undertaken for patients with learning difficulties. The practice offered longer appointments for patients who required them.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and Out of Hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice had a lead GP for mental health and held a register of patients experiencing poor mental health. There was also a dedicated GP linked with the local dementia care home. We saw evidence of effective collaboration and information sharing with

Summary of findings

community mental health services. The majority of staff had received training on dementia awareness. The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations.

The practice had safeguarding procedures to protect vulnerable adults, including those with poor mental health.

Summary of findings

What people who use the service say

Data from the national patient survey showed that patients rated their overall experience of the practice as good. 94% said the last GP they saw or spoke to was good at listening to them, 85% said the last GP they saw or spoke with was good at explaining tests and treatments, 76% said the last GP they saw or spoke with was good at involving them in decisions about their care, 84% said the last GP they saw or spoke with was good at treating them with care and concern. 98% had confidence and trust in the last GP they saw or spoke with.

We reviewed 18 comment cards where patients and members of the public shared their views and experiences of the service. All of these comments were positive about the service they experienced. Patients said the practice offered an excellent service and staff were friendly, caring, helpful and professional. They said staff treated them with dignity and respect.

We spoke with seven patients on the day of inspection and the comments we received were all positive and described excellent care.

Areas for improvement

Action the service MUST take to improve

- Ensure there are clear arrangements in place for the management of obtaining, safe storage and handling of medicines.
- Ensure recruitment processes include all required pre-employment checks in order to minimise the risks to the health, safety and welfare of patients.
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the health, safety and welfare of patients and staff in respect of infection control and fire safety procedures.

Oxshott Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector with a GP Specialist Advisor.

Background to Oxshott Medical Practice

The practice is situated in the village of Oxshott and provides a range of primary care services to approximately 7,000 patients. The practice has five GPs made up of two GP partners and 3 salaried GPs. There are three female GPs and two male. The practice also employs two practice nurses. The practice is open from 8am until 6.30 pm Monday to Friday with appointments available from 8am to 6pm. There are extended opening hours on Monday and Tuesday evenings from 6.30 to 7.30 pm.

The practice provides clinics for particular patient groups. These include flu, antenatal care, cervical screening, minor surgery, leg ulcer and wound clinics, childhood and adult immunisations

The practice has a higher than average number of registered patients over 65 years of age for England. This is partly due to the proximity of a large nursing and assisted living care home in the locality. The percentage of registered patients suffering deprivation (affecting both adults and children) is much lower than the average for England.

The practice had opted out of providing out of hours services to their own patients. Patients were able to access out of hours services through NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including the Surrey Downs Clinical Commissioning Group CCG, NHS England and Health watch to share what they knew. We carried out an announced visit on 11 November 2014.

During our visit we spoke with a range of staff including, the GPs, reception supervisor, management assistant, and the practice nurse**.** We spoke with the practice manager on the telephone prior to our visit. We reviewed patient's care records and reviewed practice management policies and procedures.

We observed how staff talked with people on the telephone and in the reception and waiting area. We also reviewed 18 comment cards where patients and members of the public shared their views and experiences of the service. We also spoke with 7 patients during our visit.

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

Detailed findings

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

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

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

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, they talked to us about a recent accident in the practice and the actions they took following the accident.

We reviewed complaints received at the practice and their responses. We also looked at safety records, incident reports and minutes of meetings where these issues had been discussed. We were informed that the practice was focussing on standardising meetings to discuss significant events. This showed the practice was proactive and so could evidence a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred monthly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, following an accident at the practice shatterproof glass was installed into the front doors of the practice. In addition we saw evidence that following an incident with a patient displaying challenging behaviours, training had been arranged for all staff in this regard. Staff including receptionists, administrators and nursing staff told us they were aware of the system for recording and raising issues to be considered at the practice management and staff quarterly meetings. All staff told us they felt encouraged and confident to contribute to these meetings.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager. We were shown the system used at the practice to ensure these were managed and monitored. We tracked one incident and saw records had been completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us, for example when a request from a patient was wrongly filed and resulted in a Patient's details being incorrect. This incident was quickly identified and addressed and further staff training was provided to ensure the risk of this type of issue reoccurring was minimised or eliminated.

We were told national patient safety alerts were disseminated by the practice manager to practice staff via email and hard copy. One of the GPs had overall responsibility for ensuring the relevant staff acted on the information received. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. For example, one GP recently wrote to some patients regarding their medicine for hypertension (high blood pressure). They also told us alerts were discussed at weekly practice meetings to ensure all were aware of any relevant to the practice and where action needed to be taken. We saw minutes of meetings that evidenced this was the case.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding in 2013. We were informed that all staff were due an update in this training before the end of 2014. We asked members of medical, nursing and administrative staff about their training, they told us they found it very useful. We discussed various safeguarding scenarios with staff and their responses clearly demonstrated they knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and Out of Hours. Contact details were easily accessible and we observed they were in a prominent place in the reception area, treatment room and GP consulting rooms.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children who had been trained to level 3 and could demonstrate they had the necessary training to enable them to fulfil this role. One of the GPs was the named lead to liaise with the local

authority and other agencies in the event of a safeguarding issue arising. All staff we spoke with were aware who these leads were and whom to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable adult patients on the practice's electronic records. The practice did not have any children on their child protection register at the time of our inspection. However the systems were in place to flag a concern in the event of a child protection issue.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. We were informed that chaperone duties would be undertaken by the nursing staff if required. Patients spoken with told us they were aware of the chaperone policy but they had never considered it necessary to request a chaperone.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called EMIS which collated all communications about the patient including scanned copies of communications from hospitals and other health professionals. We observed this in practice. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. A GP was delegated the Caldicott Guardian role (a Caldicott Guardian is a senior person responsible for protecting the confidentiality of a Patients' information and enabling appropriate information sharing).

The practice did not have a system for identifying children and young people with a high number of A&E attendances. However they had access to the CCG weekly report regarding unscheduled attendances by children and adults. We were informed that the practice manager circulated this information when it was received and that GPs reviewed it and followed up with patients.

Medicines Management

We were informed by the practice nurse and a GP that the practice did not have medicine policies and procedures. Nor was there a system in place for recording medicines received into the practice. We checked medicines stored in the treatment room including emergency and refrigerated medicines. We found they were stored securely and were only accessible to authorised staff. We observed that refrigerator temperatures had been checked and recorded in a notebook up until September 2014. However the practice nurse advised us that records were no longer kept as hard copies but were recorded on the practice IT system. We asked to see records dated from October 2014. The records we saw evidenced that the required checks had been undertaken.

We were informed that processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates; however no records had been kept of these checks. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by the practice nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to Patients repeat medicines were managed. This helped to ensure that Patient repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We observed this in practice during our visit. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice participated in a quarterly prescribing audit and review in conjunction with the local clinical commissioning group. This enabled the practice to ensure safe and effective prescribing practices.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a contract with an external cleaning company which specified the cleaning requirements and frequencies. This was checked on a regular basis.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable

gloves, and coverings and cleaning chemicals were available for staff to use. Staff spoken with were able to describe how they would use these in order to comply with the practice's infection control policy. For example, the use of personal protective equipment whilst undertaking minor surgical procedures and dressings. There was also a well-publicised policy for needle stick injury.

The practice did not have a lead for infection control. We were informed that both practice nurses were responsible for monitoring infection control within the practice. Staff had received infection control training specific to their role. We saw evidence that an infection control audit had been undertaken on 3 October 2014. We were told however, the person undertaking the audit did not have any training in this area. It was unclear to us how this person could undertake the audit without the appropriate training. We asked to see audits from 2013 but staff were unaware if previous audits had been undertaken. Practice meeting minutes showed the findings of the audit had been discussed.

We were told that on 15 October 2014 one of the practice medical students undertook an audit of hand washing techniques carried out at the practice. They found poor hand washing techniques by a number of staff. Following the audit they presented their findings at one of the practice education meetings. We were shown this presentation. As a result of the findings better hand hygiene techniques signage was displayed in staff and patient toilets, consulting and treatment rooms. We observed these were in place. More supplies of liquid hand soap, hand sanitising gel and hand towel dispensers had been made available in treatment rooms and toilets, and hand sanitising gel had been made available on the GPs consulting room desks.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. We saw the practice had a clinical waste contract and that waste was collected weekly. All clinical waste bins were of the rigid type, had been supplied with orange bags and were pedal operated. Sharps boxes were appropriately stored in the treatment and consulting rooms. We asked staff about the arrangements in place in the event of bodily fluid spills. They discussed the spillage kits in use at the practice and were clear about their responsibilities. We observed this in practice when a child became unwell and vomited on the carpeted reception floor. This incident was managed in accordance with clinical guidance and the practice policy and procedures.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We found all portable electrical equipment had been routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. On the day of our visit the portable appliances testing (PAT) was underway and we saw in practice the calibration of relevant equipment for example the heart defibrillator.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications and registration with the appropriate professional body. However there was no proof of identity, for example a current photograph. Criminal records checks via the Disclosure and Barring Service had not been undertaken on all clinical staff. However we were shown evidence to indicate that DBS checks applications were in the process of being completed. Risk assessments had been undertaken regarding the administration staff and evidenced none of the reception or administration staff had required a DBS check.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff spoken with were satisfied with this arrangement. We were informed that the practice rarely used locum GPs and in the event of having to use one they would contact a well know GP who had been a partner at the practice. This was confirmed by a number of staff we spoke with.

Staff spoken with told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were

kept safe. However during our visit we were told one of the practice nurses had submitted their resignation and would be leaving at the end of 2014. We spoke with the GP about the impact the reduced number of nurses might have on patients and we asked what arrangements they had put in place to recruit a new practice nurse. The GP told us they were confident that a replacement practice nurse would be found in a timely manner. We noted that an advertisement regarding a practice nurse was being drafted on the day.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw that a range of up to date risk assessments had been undertaken which included the work environment, the premises, equipment, security and health and safety.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff apart from one we spoke with knew the location of this equipment and records we saw confirmed this equipment was regularly checked. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

Emergency medicines were available in a secure area of the practice and all staff knew of their location, apart from one person. This was discussed with the GP partner at the time who advised they would follow this up with the staff member identified. Emergency medicines included those for the treatment of cardiac arrest and anaphylaxis. However we were unable to locate any medicines that would be used to treat hypoglycaemia (hypoglycemia is a medical emergency that involves a low content of sugar in the blood). All of the staff spoken with were clear about the protocol in place to manage health emergencies, for example, the use of basic life support techniques and calling an ambulance. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for purpose.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. Staff informed us that regular fire drills were not undertaken, nor could they remember one being undertaken. The GP Partner explained that was because the building the practice was located in was part of and leased from the local community centre. We were told fire drills were carried out at the community centre when the practice was closed at weekends. The GP Partner informed us the issue would be discussed at the next practice meeting. However, fire evacuation procedures, exit points and assembly points were well known to all staff and regularly discussed at staff meetings.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. For example, in the event of a number of staff being incapacitated at the same time such as an influenza pandemic situation the Practice manager or Senior GP Partner would assess the impact on the business of the practice and implement the contingency plan to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. We saw evidence to indicate that the practice had recently started up a diabetic clinic and that a lead GP and practice nurse were in place to support this clinic. We were informed that an audit of young adults with poor lifestyle whereby they presented regularly with various health issues had identified some of them had diabetes. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of diabetes. The review of weekly practice meeting minutes confirmed this happened.

Management, monitoring and improving outcomes for people

The practice provided us with evidence of clinical audits undertaken during the last two years. Examples of clinical audits included; whether the development of care plans for frail elderly patients made a difference to outcomes for patients and minor surgical operations. The practice was able to demonstrate changes as a result of the audits. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, in response to a safety alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) the practice undertook an audit of the prescribing of medicine for hypertension (high blood pressure). As a result the practice stopped prescribing the drug to some patients identified at risk of ill effect. We also noted following an alert from the local CCG regarding guidance around the prescribing of another medicine one of the GPs had identified a baby who had been prescribed this medicine and emailed all of the GPs in the practice regarding the guidance change.

National data showed the practice was in line with referral rates to secondary and other community care services for most conditions. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks. One patient we spoke with on the day of inspection told us how effective the practice had been in promptly diagnosing their urgent acute condition.

We saw evidence of multi-disciplinary meetings which were held with other health professionals to support patients receiving palliative care and their families and carers. In addition we noted a representative from the clinical staff attended prescribing meetings, primary care elective meetings and CAMHS meetings (Child and Adolescent Mental Health Services). We saw evidence of effective planning of care for patients with long term conditions and complex needs. We saw data from the local CCG of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice had also completed a review of patients with high blood pressure which showed that all appeared to be in receipt of appropriate treatment and regular review. The practice used computerised risk stratification tools to identify patients at risk of hospital admissions and patients identified had admission avoidance care plans in place.

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

The practice had a system for completing clinical audit cycles. The practice showed us three clinical audits that had been undertaken in the last year. The GPs told us clinical audits were often linked to improving practice and treatment outcomes for patients. For example, the practice had recently undertaken an audit of hand washing techniques to determine if the infection control processes

Good

Are services effective?

(for example, treatment is effective)

in place were effective. The audit found hand washing practices were poor. Following the audit they presented their findings at one of the practice education meetings and appropriate actions were taken.

Other examples of clinical audit included a review of younger adults presenting as unwell and being diagnosed with diabetes. The practice recently undertook an audit of the prescribing of medicine for hypertension (high blood pressure) following a safety alert issued by the Medicines and Healthcare Products Regulatory Agency. As a result the practice stopped prescribing the drug to some patients identified at risk of ill effect. We were informed plans were in place to review and monitor the results again in the next 12 months.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a national performance measurement tool.

QOF data showed that the practice performance was comparable with the national average. For example, the number of patients with physical/mental health conditions where notes contain an offer of support within the preceding 15 months was higher than average.

The practice was making use of clinical meetings to assess the performance of the GPs and to update their personal learning plans. We were informed the practice had a weekly education meeting held on a Tuesday. The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where these could be improved.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support, safeguarding of vulnerable adults and children and fire safety. However, none of the staff had been involved in a fire drill. The practice had recently introduced a system which offered e-learning training in all the mandatory training topics for all staff. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Although staff we spoke with told us they had undergone annual appraisal discussions, there was very little detail in the documents and none of the documents had been signed by the appraiser or the staff member appraised. We examined personnel files and found there was no documentation in place that demonstrated each member of staff had a personal development plan, nor were there any records to indicate staff had had the opportunity to talk through any issues about their role where appropriate. One staff member described their appraisal discussion as being very brief.

The practice nurse spoken with told us they provided support to a wide range of patients with long term conditions, such as asthma, diabetes and chronic obstructive pulmonary disorder. Although they had previously undergone training in these areas, they told us that they had not recently received any update training. They told us they identified their own training needs and had recently undertaken a diploma in the care and treatment of asthma patients. We were informed the nurse funded this course. The nurse we spoke with informed us they did not attend clinical meetings. However the other practice nurse did attend the weekly meetings. We reviewed the minutes of meetings held in 2014 and they confirmed what we had been told. Other staff spoken with discussed the recent dementia training provided by staff from a local care home. They told us the training was very helpful and helped them gain a better understanding of the challenges presented to people with dementia.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. All relevant staff were clear on their responsibilities for passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for updating of clinical records and other actions required. All staff we spoke with understood their roles and felt the system worked well.

Good

Are services effective?

(for example, treatment is effective)

The practice had held a register of patients with poor mental health and those with learning disabilities. We saw evidence of effective collaboration and information sharing with community mental health services.

The practice held regular multidisciplinary team meetings to discuss patients with complex needs. For example, those receiving end of life care, patients with a cancer diagnosis. These meetings were attended by district nurses and palliative care nurses. Patients with palliative care needs were supported using the Gold Standards Framework (Gold Standards Framework is an evidence based approach to optimising care for all patients approaching the end of life). The practice had a virtual ward approach whereby its aim was to prevent unplanned admissions to hospital by using multidisciplinary case management in the community. A community matron visited the practice on a regular basis to discuss frail and elderly patients and provide support to the GPs.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw these systems working in practice during our visit.

The practice communicated effectively with the Out of Hours service to ensure they received care plans and notes of vulnerable patients and those receiving end of life care. GPs within the practice provided their own telephone numbers to provide additional support out of hours for those receiving end of life care. The practice computer system enabled alerts to be added to patient records. GPs used this to highlight particularly vulnerable patients.

Consent to care and treatment

Patients we spoke with told us that clinicians always obtained consent before any examination took place.

The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The GPs and practice nurse we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. The practice nurse spoke about gaining consent from patients prior to undertaking cervical cytology procedures.

We found that most staff had some awareness of the Mental Capacity Act 2005 and their duties in fulfilling it. GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples of how a patient's best interests were taken into account if they did not have capacity to make decisions or understand information. We spoke with one nurse who was not clear on the principles or its application. Other staff reported that they had safeguarding training which covered the Act. However they told us the information was not detailed enough for them to gain a clear understanding around mental capacity. They did however refer to patients with dementia and their limited ability to make decisions.

The GPs and nurse demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions. We saw that medical reviews for those patients took place at appropriately timed intervals. Staff told us they also offered health checks with the practice nurse, to any patient who requested a check. The practice routinely offered new patients registering with the practice a health check via a health questionnaire. However new patients requiring repeat medicines were required to meet with the GP on registration.

The practice identified those patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and mental health problems. We noted the practice had a link with a local dementia care home where they provided twice weekly surgeries on a Monday and a Friday. The GP Partner told us the Friday surgery was particularly beneficial because they were able to identify and treat patients who otherwise may call on the emergency services over the weekend.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, some simple travel vaccines, flu and shingles vaccinations in line with current national guidance.

Patients requiring support to stop smoking were offered smoking cessation advice and signposted to the local smoking cessation clinic.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that patients rated their overall experience of the practice as good. 94% said the last GP they saw or spoke to was good at listening to them, 85% said the last GP they saw or spoke with was good at explaining tests and treatments, 76% said the last GP they saw or spoke with was good at involving them in decisions about their care, 84% said the last GP they saw or spoke with was good at treating them with care and concern and 98% had confidence and trust in the last GP they saw or spoke with.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 18 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were kind, efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven patients on the day of our inspection. Their responses to our questions demonstrated that they thought very highly of the GP practice and their staff. They told us that they were very satisfied with the care provided by the practice and said their dignity and privacy was always respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Separate examination and treatment rooms, attached to the consulting rooms, ensured that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard. Patients spoken with told us if they wished to discuss anything in private this was accommodated. They talked about using the practice manager's room on occasion to discuss confidential issues with reception staff prior to seeing their GP. PPG representatives spoken with told us the staff at the practice listened to their concerns about patient confidentiality and as a result the telephone was moved from the front of the reception area to the rear area of the office so as conversations could not be overheard. We observed this in practice on the day.

The majority of staff in the practice had received some dementia training. This allowed staff to understand the needs and communication difficulties and challenges that could arise for patients with this condition. Staff told us this training was very helpful and provided them with some of the skills required to identify these concerns and support the patient in alternative ways.

Care planning and involvement in decisions about care and treatment

Patients told us they had enough time during consultations to ask questions and be involved in decisions about their care and treatment. GPs were aware of what action to take if they judged a patient lacked capacity to give their consent.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 76% said the last GP they saw or spoke with was good at involving them in decisions about their care, and 85% said the GP was good at explaining treatment and results.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. 90% said the last GP they saw or spoke to was good at giving them enough time. Patient feedback on the comment cards we received was also very positive and reflected these views.

We saw evidence of care planning for people with long term conditions, vulnerable patients and those patients receiving palliative care.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing Patients this service was available. We noted there was a quick link to translation services on the practice website.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of respondents to the national GP patient survey said the last GP they or spoke to within the practice was good at treating them with care and concern. The patients we spoke to on the day of our inspection and the comment cards we received also highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice provided extensive information to support patients and their carers to access support groups. This included a carer's resource file and information pack. During our discussions with staff it was clear that the practice provided sensitive support for bereaved patients' families. We saw copies of letters sent to families following a patient's death, and staff talked about attending funerals and sending flowers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and they understood their patient population. The NHS Local Area Team (LAT) and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Longer appointments were available for patients who needed them and for those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made.

Working age patients were able to book appointments and order repeat prescriptions on line. Patients reported that repeat prescription requests were processed very quickly.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had a proactive patient participation group. We spoke with them during our visit. They talked about recruiting patients into the group and had 10 patients in the group that met with practice staff including a GP, practice manager and administrative staff. They also had a virtual group that consisted of 350 members. In June 2014 they undertook a patient survey and following the survey they suggested improvements to the practice. For example; more privacy at the reception desk and signage requesting that patients in the queue allow other patients their privacy. We were told the practice were very receptive and supportive. We observed the changes had been implemented. The survey also sought patients' opinions as to whether the practice appointments system could be improved. The findings of the survey resulted in the practice providing a combination of open access and pre-bookable appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were well supported. The practice talked about the demographics of the area. They told us there were no patients with no fixed abode on their register but if the need arose they could register and be treated at the practice.

Staff told us that translation services were available for patients who did not have English as a first language.

The practice was situated in premises on one level. There was a ramp access from the outside and a reasonably sized waiting area for wheelchair and prams. However, access for patients with mobility issues was limited. It would not have been possible for a wheelchair user to access the toilet facilities due to lack of space. Consultation rooms were spacious with sufficient room for wheelchair users. The toilet facilities available had been modified as much as was practicable within the limited space available and hand rails had been provided here were no baby changing facilities at the practice. We had discussions with one of the partners about the perceived challenges around the environment. They informed us they were in the early stages of discussions with various agencies about further development of the practice environment.

Access to the service

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated.

Appointments were available in a variety of formats including pre-bookable appointments, urgent same-day appointments and telephone consultations and home visits. The practice was open from 8am to 6.30pm on weekdays. The surgery provided access to urgent appointments throughout the day. Late evening appointments were available to patients on one evening per week. Patients were able access an appointment with a female GP if requested. The practice had implemented a system whereby a text confirmation of appointments and reminders was sent to patients 48 and 24 hours prior to their appointment time.

The practice had its own website which provided information to patients on opening hours and appointment availability, via the NHS Choices website. Patients could book appointments and organise repeat prescriptions via a link website. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them.

A number of comments we received from patients confirmed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. One patient we spoke with

Good

Are services responsive to people's needs?

(for example, to feedback?)

immediately prior to their appointment told us how they often needed an urgent appointment due to a specific medical condition and they were always seen on the same day. Another patient told us if their child was unwell they would always been seen on the day.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed at weekends, after 6:30pm Monday to Friday and on bank holidays. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the Out of Hours service was provided to patients on the practice website, practice leaflet and appointment information advertised in the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the lead for complaints and handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were leaflets in the waiting room to describe the process should a patient wish to make a compliment, suggestion or complaint. The practice website also signposted patients to the suggestions and complaints policy. A suggestion box was available to patients in the waiting area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We reviewed the practice complaints log. We found there had been six complaints within the last 12 months. The practice had investigated all the complaints and implemented appropriate actions. Learning points had been discussed at meetings between the GPs the practice manager and one of the nurses and fully documented.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice did not have a written statement about their vision and ethos. However all of the staff we spoke with could articulate their understanding of the practice ethos to deliver high quality care to the patients. They talked about the open door culture within the practice, the effective communication, co-operation and support and their pride working at the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were available to staff through the practices intranet. We looked at four policies and saw that the practice had a version control system in place to ensure that each policy was reviewed annually, updated and current. We saw evidence that most staff had signed to confirm that they had read and understood the policies.

The practice had a clear structure and schedule of meetings to govern its business. This included weekly practice business meetings with regular agenda items, such as diary and staffing issues, priorities, start the week newsletter from the CCG, significant events, complaints and the business development plan.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed good achievement in clinical areas. They achieved the second highest scores in their CCG area in identifying patients with diabetes. Subsequently they had implemented a weekly diabetic clinic led by one of the GPs and a practice nurse. The practice had set up a dementia initiative whereby if a patient was at risk of or was showing signs of dementia, the practice nurse visited those patients in their homes to undertake memory tests.

We could find no evidence to indicate regular discussions around QOF apart from the quarterly meetings. We reviewed the minutes of all of the practice meetings for 2014 and could see no evidence of QOF monitoring and discussions at these meetings.

The practice had completed a number of clinical audits, for example a review of patients in the practice being prescribed a medicine following a safety alert and a review of the effectiveness of care plans for the frail elderly. Also the practice had recently undertaken an audit of hand washing techniques to determine if the infection control processes in place were effective. The audit found hand washing practices were poor. Following the audit they presented their findings at one of the practice education meetings and appropriate actions were taken.

Other examples of clinical audit included an audit of younger adults who presented frequently as being unwell with coughs and colds and being diagnosed with diabetes. The practice recently undertook an audit of the prescribing of medicine for hypertension (high blood pressure) following a safety alert issued by the Medicines and Healthcare Products Regulatory Agency. As a result the practice stopped prescribing the medicine to some patients identified at risk of ill effect. We were informed plans were in place to review and monitor the results again in the next 12 months.

The practice had arrangements for identifying, recording and managing risks to patients, staff and visitors. We saw that a range of up to date risk assessments had been undertaken which included the work environment and the premises, equipment and flu pandemic

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, the safeguarding lead, clinical lead and QOF lead. The staff we spoke with were clear about their own roles and responsibilities. They all told us since the changes in management and GPS they felt more valued, well supported and knew who to go to in the practice with any concerns.

There were weekly practice meetings for GPs and some administrative staff. Reception and administrative staff told us they had regular support meetings and attended quarterly practice wide meetings. They also talked about the social events they attended as a team. Staff told us that there was an open culture within the practice. They felt confident about raising concerns and that they would be listened to.

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

The practice had gathered feedback from patients through the patient participation group (PPG), annual surveys and complaints. The practice had an active PPG which met regularly, with one of the GP partners and the Practice

Are services well-led?

Good

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

Manager. We looked at the PPG report on the last patient survey which provided an analysis of the results and identified areas for action. There was evidence that the practice had implemented an action plan as a result.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistle blowing policy which was available to all staff, however some staff could not explain what the policy was for. Other staff were able to discuss scenarios whereby they would use the policy and procedure and demonstrated confidence to do so.

Management lead through learning and improvement

Staff told us that they were supported by the practice. We looked at four staff files and saw that they had undergone an appraisal. However, there was very little detail in the documents and none of the documents had been signed by the appraiser or the staff member appraised. There was no documentation in place that demonstrated each member of staff had a personal development plan, nor were there any records to indicate staff had had the opportunity to talk through any issues about their role where appropriate.

All of the GPs within the practice had undergone training relevant to their lead roles, such as mental health and child safeguarding. All of the GPs had undergone annual appraisal and had been revalidated.

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, safeguarding of vulnerable adults and children and fire safety. The practice had recently introduced a system which offered e-learning training in all the mandatory training topics for all staff. We were informed that an educational meeting took place every Tuesday mainly for clinical staff, where particular patient's cases would be discussed. We noted in the practice minutes that a number of the clinical staff had attended training in learning disabilities.

There was evidence that the practice had completed reviews of significant events and other incidents and shared with the appropriate staff via meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The provider had failed to ensure effective systems were in place to identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 10 (1) (b) (2).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The provider had failed to ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying out the regulated activity, and such other information as appropriate. Regulation 21 (b). Schedule 3

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met. The provider had failed to ensure that appropriate arrangements were in place for the management of medicines. There were no documented medicines policies or procedures at the practice. Regulation 13