Chawton Park Surgery

Quality Report

Chawton Park Road
Alton
Hampshire
GU34 1RJ
Tel: 01420 542542
Website: www.chawtonpark.org.uk

Date of inspection visit: 05/02/2015
Date of publication: 23/04/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Chawton ark Surgery on 5 February 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to some equipment, fire safety and legionella.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice is a training practice and has up to four trainee GPs at any one time
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Clinical audit was limited there were not any completed audit cycle. We were told that the lack of completing audit cycles had been identified by the GPs as an issue which was being addressed
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Action the provider MUST take to improve:

- Ensure that fire safety and legionella risk assessments are completed as needed.
- Ensure action is taken when the medicines/ vaccinations fridges record an unsafe temperature range.
- Ensure equipment used to administer emergency care and treatment is within use by dates for sterile items.
- Risk assess the emergency medicines storage protocol.
- Risk assess the requirement for criminal record checks for staff who act as chaperones.

Action the provider SHOULD take to improve:

- Bring infection control training up to date for relevant staff.
- Implement a system to ensure full completion of clinical audit cycles.

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 as there are areas where improvements should be made.

Systems were in place for reporting, recording and monitoring significant events. Infection prevention and control systems were in place and regular audits were carried out to ensure that all areas were clean and hygienic. Appropriate checks were made on all staff before they started employment. Staff files were comprehensive and complete. Staff that performed chaperone duties did not have either a DBS check or documented rationale why such a check was not required.

An arrangement relating to the availability of safe and secure storage of medicines and vaccinations was not effective. This included equipment used to administer medicines. Emergency planning arrangements were in place and arrangements also made with the neighbouring community hospital which meant that the service could function in an emergency.

Risks to patients who used the practice were not assessed which meant systems and processes to address these risks were not implemented and did not ensure patients were kept safe. Areas of concern found included, fire safety and legionella safety.

Are services effective?

Good

The practice is rated as **good** for providing effective services.

Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence guidance was referenced and used routinely. Multidisciplinary working was also evidenced. People's needs were assessed and care planned and delivered in line with current legislation which included assessments of a patient's mental capacity. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatment they needed in a timely manner. Staff had annual appraisals and told us that their training needs were supported by senior staff.

Are services caring?

Good

Overall the practice was rated as **good** for providing caring services.

Patient feedback was extremely positive about their experience of using Chawton Park Surgery. Patients found the staff friendly and approachable, they felt staff responded to their needs and were caring. This feedback was supported by the results of the most

Summary of findings

recent GP patient survey which showed that 95% of patients asked said the GP treated them with care and concern. Staff respected patients' privacy and dignity and a chaperone service was available to those who required it.

Are services responsive to people's needs?

Good

Overall the practice was rated as **good** for providing responsive services.

Patients reported good access to the practice and all had a named GP for continuity of care with urgent appointments available the same day. All the patients who requested a telephone consultation received a call back the same day and GPs would stay until the last call was made no matter what the time was.

The practice had good facilities and was well equipped to treat patients and meet their needs. There was an open culture within the organisation and a comprehensive complaints policy and procedure. Complaints about the service and significant events were investigated and responded to in a timely manner. While the area had a very low percentage of people whose first language was not English there was access to telephone and website language interpreting services.

Are services well-led?

Good

The practice is rated as **good** for providing well-led services.

There was a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and all the staff felt supported extremely well by management. The practice had a number of policies and procedures to govern activity and held weekly governance meetings.

There were a limited number of systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active. Staff had received inductions, regular performance reviews and 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 people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework. This meant they worked, as part of a multidisciplinary team and with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes. We saw care plans were in place for patients at risk of unplanned hospital admissions, and those aged 75 and over who were vulnerable had care plans in place.

People with long term conditions

Good

The practice is rated as **good** for the care of people with long term conditions.

Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. The practice provided extended appointments for patients with the presence of two or more long term conditions. These clinics were well attended and patients were given extended appointments and sufficient time to have their issues addressed.

All patients with long term health conditions had structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

Systems were in place for identifying and following-up vulnerable families and who were at risk.

Immunisation rates were high for all standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were very responsive to parents' concerns and ensured parents could

have same day appointments for children who were unwell. Staff were knowledgeable about child protection and a GP took the lead with the local authority and other professionals to safeguard children and families.

Working age people (including those recently retired and students)

Good

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

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. Patients were provided with a range of healthy lifestyle support including referrals available to external agencies to support people in leading healthier lifestyles.

The practice had extended opening hours enabling people to make appointments outside normal working hours. Appointments could be booked online in advance and a text message reminder system was in place to remind patients of pre booked appointments.

The practice had a system in place to identify carers, which enabled them to provide appropriate support and referrals. NHS health checks, a service which provides opportunistic or planned health check for patients aged 40-74 years were in place.

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.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice carried out annual health checks for people with learning disabilities and offered longer appointments for people where required. Staff knew how to recognise the signs of abuse and 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 maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health checks and a medicines review. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance

Summary of findings

care planning for patients with dementia. The practice sign-posted patients experiencing poor mental health to various support groups and voluntary organisations including referrals to counselling services.	

Summary of findings

What people who use the service say

We received 31 completed patient comment cards and spoke with five patients at the time of our inspection visit.

Of the 31 people who provided feedback two said their waiting time to see a GP was sometimes longer than expected. This did not reflect the results of the national GP patient survey which indicated that the practice was higher than national and local averages for patient satisfaction with waiting times of 15 minutes or less.

There was a patient participation group (PPG) in place and this group supported the practice with their surveys. Requests for volunteers to join the PPG were advertised through the practice website, leaflet and on posters displayed in the waiting area.

Patients we spoke with and who completed comment cards were extremely positive about the care and treatment provided by the GPs and nurses and the assistance provided by other members of the practice team. They told us that they were treated with dignity and respect and some commented that the care provided was exceptional.

We also looked at the results of the GP patient survey published in January 2015. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey showed that the practice achieved better than average results for both the clinical commissioning group area and nationally.

Results included;

- 96% of respondents found it easy to get through to the practice by phone.
- 94% of respondents said the last appointment they got was convenient.
- 100% of respondents said they had confidence and trust in the last GP they saw/spoke to.
- 80% of respondents said the nurse was good at treating them with care and concern.

Areas for improvement

Action the service MUST take to improve

- Ensure medicines/emergency medicines are stored in a secure manner.
- Ensure that fire safety and legionella risk assessments are completed as needed.
- Ensure action is taken when the medicines/ vaccinations fridges record an unsafe temperature range.
- Ensure equipment used to administer emergency care and treatment is within use by dates for sterile items.
- Risk assess the emergency medicines storage protocol.
- Risk assess the requirement for criminal record checks for staff who act as chaperones.

Action the service SHOULD take to improve

- Bring infection control training up to date for relevant staff.
- Implement a system to ensure full completion of clinical audit cycles.

Chawton Park Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Chawton Park Surgery

Chawton Park Surgery is situated in the outskirts in Alton, Hampshire and has been at this location since 2005. The practice shares its building with a pharmacy and is based in the grounds of Alton Community Hospital.

The practice is responsible for providing primary care services to approximately 9400 patients. Chawton Park also has a contract to provide minor injury services to people who are able to attend the practice in person. Appointments are available between 8.40am and 5.45pm Monday to Friday. The practice operates extended opening hours on Tuesday 6.30pm to 7.30pm and Friday 7am to 8am to see both GPs and nurses. The minor injury service is available between 8am and 6.30pm Monday to Friday. The practice has opted out of providing out-of-hours services to their own patients and refers them to Hantsdoc who are the out-of-hours provider. Patients can access Hantsdoc via the 111 service.

The practice has six GP partners who together work an equivalent of 5.75 full time staff. There are three male and three female GPs and a half time salaried assistant. The practice is a training practice and has up to four trainee GPs at any one time. GPs are supported by three nursing staff and two health care assistants. The practice also has an administration team of 14 which consists of receptionists, administrators, secretary, reception manager, IT manager and the practice manager.

The practice has a high number of patients who are aged between 40 and 69 when compared to the England average. Due to the rural nature of Alton the practice has a high number of patients who reside in neighbouring villages. Also a high number of working age patients commute via train to London to work.

We carried out our inspection at the practice's only location which is situated at;

Chawton Park Surgery

Chawton Park Road

Alton

GU 34 1RJ

Why we carried out this inspection

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

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

and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with patients who used the practice. We reviewed comment cards and feedback where patients and members of the public shared their views and experiences of the practice before and during our visit.

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

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

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

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

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw a number of examples where this information was appropriately managed and action was taken when necessary. All safety alerts received were shared with the whole team at weekly clinical meetings. One example seen was when a medicine side effect alert was received by the duty doctor. Patients who could be affected by this were identified and contacted by letter the same day with an invite to attend the practice with a view to discuss alternative treatment options.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events.

The practice used 'quality improvement activity' forms which were completed in a comprehensive and timely way. Where a patient had been affected by something that had gone wrong, they were given an apology and informed of the actions taken to prevent a reoccurrence. For example, a miss communication between the practice and a patient occurred about the extra appointments system at the end of surgery. We saw that the patient had been contacted and an apology given, an investigation was carried out and discussed and recorded at the next clinical meeting, four days later, and a change was made as a result. Whilst records of significant events that had occurred were kept and fully investigated and learning evidenced an analysis of these was not performed.

Reliable safety systems and processes including safeguarding

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example if a child was subject to a child protection plan. Patient appointments were conducted in the privacy of individual consultation rooms.

All the GPs had been trained to level three in safeguarding children. The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. Staff were aware who the lead was and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew what to do if they encountered safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Training records confirmed that three of the five nursing and health care staff and nine of the 10 reception staff had received safeguarding children training.

Information about how to request a chaperone could be found on the practice website, the display screen in the waiting area and in the practice leaflet. We were told that the practice had 10 chaperones. Training for these staff was given by a member of the administration team who attended a chaperone course and then cascaded information and written material to other staff. We found that these staff had not received a disclosure or baring service check. We asked about this and were told that at no time would a chaperone be left alone with a patient. This arrangement was confirmed by staff who were chaperones but was not recorded formally in any risk assessments or the chaperone policy. We talked with the practice manager about the need for this to be carried out or a documented rationale why such checks were not required.

National guidance states that clinical staff and those dealing with vulnerable people should have checks on their character and suitability to carry out their role.

Medicines management

We checked medicines that were stored in treatment rooms and medicine fridges and found that these were secure. Emergency medicines were stored in a cupboard in a corridor which was out of sight of staff. We found this to be unlocked. We spoke with a nurse about this who said they kept it unlocked to allow quick access to the emergency trolley but understood the risk associated with not securing medicines and said the cupboard would be locked immediately.

The practice had four fridges. Certification confirmed that all four fridges were calibrated in December 2014. Records kept by staff showed that vaccines and medicines stored in these fridges were generally stored within a safe temperature range of between two and eight degrees

Are services safe?

Celsius. However records seen for January 2015 showed that temperatures rose above eight degrees on several occasions overnight but there was no evidence of what action had been taken as a result of this.

Vaccines such as for flu and shingles were administered by nurses and health care assistants who were appropriately trained and followed national guidelines and under a patient group direction. Patient group directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs.

A procedure was operated to enable patients to request and obtain their repeat prescriptions either online or in person. Prescribing audits were carried out. For example, an audit of patients that were prescribed long term antibiotics required health checks to monitor any side effects. This audit identified improvements required to the patient health check recall process. Improvements were made as a result.

Cleanliness and infection control

All areas of the practice appeared to be well maintained, clean and fit for purpose. An infection control policy and supporting procedures was available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment which included disposable gloves and aprons was available for staff to use and staff were able to describe how they would use these in order to comply with the policy.

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

Staff training records showed that two of the five nursing and health care staff and six of the seven GPs had completed infection control training in 2014.

Sharps boxes were provided and were positioned out of the reach of small children.

Clinical waste was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed.

The most recent infection control audit was carried out in December 2014 which identified six areas of concern and these were detailed in an action plan. For example, a missing practice cleaning plan and storage/cleaning of mop heads. We were told that actions required to remedy these had not been undertaken. The action plan also did not show a date for when actions required should be completed. We asked for evidence to confirm that a legionella risk assessment had taken place. We were told that one had been booked to take place the week following our inspection and water quality testing had not taken place prior to our visit.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested

and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Material curtains were used in the treatment and consulting rooms and a cleaning plan was followed to minimise the risk of cross infection.

All portable electrical equipment was routinely tested and displayed stickers indicating that December 2014 was the most recent date tested. Records showed that medical equipment had also been calibrated in December 2014. Pieces of equipment calibrated included, blood pressure monitors, medicine and vaccination fridges and weighing scales. The fire alarm system was serviced in May 2014 and fire extinguishers were serviced in August 2014.

Staffing and recruitment

The practice had a recruitment policy in place which was reviewed in July 2014. There was a clear process in place to recruit new staff. This included, application form, job description, job offer/rejection letter templates.

The staff team were well established and most had worked at the practice for many years. The staff were also multi

Are services safe?

skilled which enabled them to cover each other in the event of planned and unplanned absence. For example, two receptionists were also administrators and three were secretaries.

We looked at three staff files for staff that started to work at Chawton Park since 2013 and saw that some of the employment checks that were required to be carried out had not been completed. For example references regarding conduct in previous employment and photographic proof of identity. All of the GPs had disclosure and barring service (DBS) checks undertaken. Nurses had DBS checks completed but only one of the two health care assistants had been checked.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medicines, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. However, the practice had not carried out risk assessments for both legionella and fire safety.

Staff reported that they would always speak to the practice manager if an accident occurred and ensure that it was recorded. This and all other practice policies were available to all staff at any time via the practice computer system.

Arrangements to deal with emergencies and major incidents

Of the 32 staff working at Chawton Park records showed that 28 staff received resuscitation (basic life support) training between 2011 and the date of our visit. Of these five were trained in 2014 and 13 in 2013. Staff knew the location of the emergency medicines and equipment which included an automated external defibrillator and oxygen.

We saw that emergency drugs and equipment were regularly checked by a lead nurse. However we found four pieces of equipment used to administer emergency medicines to be out of date. Two of these were over five years past their use by date. There was also only a reliance on local knowledge of what should be in the emergency trolley as a list was not maintained.

The practice had an electronic emergency call system in place on every computer and telephone to enable staff to call for help if they needed urgent assistance. This could be for safety or medical reasons.

A disaster recovery plan, dated 2011, was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of computer system, incapacity of GPs and loss of medical records. There were reciprocal arrangements in place with the neighbouring hospital in the event of an emergency evacuation. The document also contained relevant contact details for staff to refer to.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff outlined the rationale for their treatment approaches. They were familiar with current best practice guidance by accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Information reviewed confirmed that patients were given support to achieve the best health outcome.

Clinical guidelines were available to staff via the practice computer system. For example, dermatology referral pathways for a patient with a skin condition such as a wart followed clinical commissioning group protocols and information given to patients was based on patient.co.uk guidelines. We also saw that for the management of asthma staff referred to British Thoracic Society standards. GPs used a score system for risk assessing potential/ current conditions such as deep vein thrombosis, diabetes, kidney disease and ABCD for stroke. For example, the ABCD score is a risk assessment tool designed to improve the prediction of short-term stroke risk after a transient ischemic attack).

We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to systems were shared with appropriate staff. Interviews with GPs and staff showed that the culture in the practice was that patients were referred on need and not adversely influenced by patient age, gender and race.

The GPs had lead roles in specialist clinical areas such as diabetes and medicines management. Practice nurses supported this work but were also leads for asthma, high blood pressure and immunisations.

Management, monitoring and improving outcomes for people

We were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes and high cholesterol. A range of patient information was available for patients which helped them understand their conditions and treatments. Staff said they could openly raise and share concerns about patients with colleagues at weekly clinical meetings which enabled them to share knowledge and discuss patient care.

The practice actively used the information they collected for the Quality and Outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma, diabetes and heart failure. They were also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 100% of children at 12 months had received the 5-in-1 vaccine, also known as the DTaP/IPV/Hib vaccine.

The practice had a system in place for carrying out clinical audits and sharing learning with relevant staff. For example, we saw an audit of joint injections carried out over a period of three months which identified infection and/or pain being reported by patients following joint injections to areas such as a shoulder, knee or finger. We saw an initial summary but no date for reassessment was given. Other examples seen included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. We looked at five clinical audits in total and found that none had evidence of a completed audit cycle. We were told that the lack of completing audit cycles had been identified by the GPs as an issue which was being addressed.

Effective staffing

There was enough qualified, skilled and experienced staff to meet people's needs. The practice employed seven GPs, five nursing staff, 14 reception and administration staff and three managers who worked flexibly at the practice. We observed all staff working professionally and there was a friendly atmosphere at the practice. Staff we spoke with told us that the staffing levels were suitable for the size of the service.

There were appropriate arrangements for staff appraisal and the revalidation of GPs. Staff confirmed there were annual appraisal meetings which included a review of performance and forward planning including the identification of learning and development needs. 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

Are services effective?

(for example, treatment is effective)

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.

We saw there was a structured induction programme in place for new members of staff and GPs and records confirmed this was used. There were arrangements in place to support learning and professional development. Nursing staff told us how they were responsible for chronic disease management, for example diabetes and asthma. Staff were appropriately qualified and competent to carry out their roles safely and effectively.

We reviewed the results of the GP national survey, published in January 2015, which showed a positive patient attitude towards the practice. For example, 89% of respondents had confidence and trust in the last nurse they saw or spoke to.

Working with colleagues and other services

We found the GPs, nurse practitioner, nurse and health care assistants at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. GPs and nurses attended multi-disciplinary team meeting to ensure information was shared effectively.

The practice worked with associated health professionals' including occupational therapists, district nurses and the community mental health team to support the needs of patients.

Patient information was stored on the practice's electronic record system which was held on practice computers that were all password protected. This information was only accessible to appropriate staff. All staff who worked at the practice were aware of information governance.

We saw this referred to in the induction process and staff were aware of their responsibilities.

The practice had an area which contained historical paper patient records. This was located securely away from the public areas of the practice and accessed only by authorised staff.

The IT manager was the Caldicott guardian. A Caldicott guardian is a person responsible for ensuring the safe keeping and appropriate use of information.

Information sharing

Patients received coordinated care and support where more than one provider was involved or they were moved between services. We saw evidence to confirm that arrangements were in place for engagement with other health and social care providers.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC information was shared with local care services and out of hour providers. For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings which monitored patient welfare and provided the best outcomes for patients and their family.

Information was shared between the out of hour's (OOH) service and the practice. Any information received by the practice from the OOH service was discussed by GPs the following morning and action taken as appropriate.

Consent to care and treatment

GPs and staff explained the discussions that took place with patients, to help ensure they had an understanding of their treatment options. We reviewed data from the national patient survey published in January 2015. This showed the practice was rated above the local and national patient satisfaction average by patients who were asked how good they felt the GP was at involving them in decisions about their care and treatment. Of the patients asked, 88% said they felt the GP was good or very good.

The practice had a consent policy which included implied consent, expressed consent and how staff should obtain consent. We were told by staff that before patients received any care or treatment they were asked for their consent and the GP/nurses acted in accordance with their wishes.

There were arrangements in place to secure the consent of patients who lacked ability to make their own decision. We were given an example of when a patient's mental capacity was assessed when an enduring power of attorney was requested.

Staff demonstrated an understanding of the Gillick competence when asked about treating teenage patients.

Are services effective?

(for example, treatment is effective)

Gillick competence is a term is used in medical law to decide whether a child, 16 years or younger, is able to consent to their own medical treatment, without the need for parental permission or knowledge.

Health promotion and prevention

The practice encouraged patients to take an interest in their health and take action to improve it. We saw a large range of health promotion information available both at the practice and on its website. This information included information about preventative health care services being offered. For example, bowel screening and vaccinations for shingles. The practice also offered patients, who wished to lose weight, support by providing dietary advice services. We saw details of this in the practice leaflet and on the practice website.

New patient registration form included information about a patient's medical history, alcohol intake, smoking status, diet, and carer responsibility. New patients were also asked to complete a health check eligibility questionnaire. Arrangements were in place to flag up concerns about patients' health with a GP or nurse lead. The practice recorded that only 18% of patients aged between 40-75 years old had received an NHS health check in the last 12 months. The practice manager told us they knew this figure was lower than the local average and advertised the health check on its website and on the electronic screen in the waiting area as well as GPs prompting patients during their consultations.

The practice offered travel information for patients who were intending to travel was included on the practice website.

The practice also offered a full vaccination program for all children who were registered. This included Measles, Mumps and Rubella Polio and Tetanus.

Flu vaccinations were offered to all the patients who were eligible (those over 65, in risk groups or pregnant). We were told that 69% patients came forward for this so far in the current 12 month period ending March 2015. Shingles vaccinations were also offered and 63% of those patients invited took this up over the same period as the flu vaccinations.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The layout of the waiting area meant that the reception desk was in the same location but staff were aware of the need for people's privacy to be respected and were heard speaking in a quiet manner. There was also a separate room available for patients to request should they wish to speak to reception staff in private. Records confirmed that 13 staff had received information governance training and all GPs had received equality and diversity training.

Consulting and treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times patients were with GPs and nursing staff. Conversations between patients and GPs and nurses could not be heard from outside the rooms which protected patient's privacy. All the treatment and consulting rooms contained a curtain around the examination couch which protected patient's privacy.

We looked at the results of the most recent GP patient survey, published in January 2015. This

is an independent survey run by Ipsos MORI on behalf of NHS England. Results showed the practice was rated above the local clinical commissioning group and national patient satisfaction. Patients were asked how they felt GPs and nurses treated them with care and concern, giving them enough time and listened. Of the patients asked, 100% said they had confidence and trust in the GPs. We were given two examples of situations where GPs worked closely with patients. One needed confidential sexual health advice without the knowledge of their partner and the other was supported to have a medical screening procedure that they had never received before and were anxious.

Care planning and involvement in decisions about care and treatment

The same GP patient survey reported that 88% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care. The survey showed that 61% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in making decisions about their care. Patient feedback on the CQC comment cards we received was also positive and aligned with these views.

The practice maintained care plans for patients who required regular or specialist treatment. The practice had a system in place for identifying people who would benefit from a care plan. We looked at some of these plans and saw that they were well written and considered appropriate measures for on-going effective health management for patients. GPs and nurses demonstrated

excellent knowledge of appropriate referrals to other healthcare professionals. For example, a patient became unwell but their wishes to not be admitted to hospital were respected and they were referred instead to the community nurses who carried out home visits.

Patient/carer support to cope emotionally with care and treatment

Information in the patient waiting room and patient website told people how to access a number of support groups and organisations. For example, CRUISE i-talk. The practice's computer system alerted GPs if a patient was also a carer. We were told that families who had suffered bereavement were called by the GP to offer support and condolences.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable, such as people with long term health conditions, dementia, learning disabilities, poor mental health and older people. For example, longer 30 minute appointments were available for patients who had poor mental health together with additional health problems.

Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening. For example, patients exposed to asbestos in the area were coded on the computer system which triggered smoking cessation advice and support.

We saw that the practice had been proactive in seeking and responding to patients. The practice had an effective and active patient participation group (PPG) and we saw that information about the PPG was displayed in the reception area. A section of the practice website provided information about patient satisfaction and how it responded to patient needs and suggestions. PPG members that we spoke to told us that the practice was very good at responding to any issues raised. One example of this was introduction of text messaging appointment reminders as a result of feedback received from patients via the PPG.

Tackling inequity and promoting equality

The practice was accessible to anyone who required level access. We saw disabled person's parking spaces close to the entrance door. A wheelchair accessible toilet was available and there was also a baby changing facility for mothers with babies to use. The reception desk was low in places which accommodated wheelchair users without them needing to move to a separate area. All the consulting rooms were on the ground floor and a lift was available for anyone who needed it to access the first floor. An induction loop was also available for those who were hard of hearing.

Staff told us that there was little diversity of ethnicity within their patient population. However they were knowledgeable about language issues and told us about the language line available for people who did not use English as their first language. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

Staff had a clear understanding of the triage system to prioritise how patients received treatment, if they needed an appointment or how the GPs would decide to support them in other ways, for example, a home visit could be given for patients who were too ill/frail to attend the practice. This would require a call to the practice before 10am.

Comprehensive information was available to patients about appointments in the surgery and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

Appointments were available between 8.40am and 5.45pm Monday to Friday. The practice operated extended opening hours on Tuesday 6.30pm to 7.30pm and Friday 7am to 8am to see both GPs and nurses. The practice also offered a minor injury service between 8am and 6.30pm Monday to Friday. GPs and nurses treated patients who were able to walk into the practice without an appointment if an accident had occurred during the last 24 hours over weekdays or 48 hours over weekends.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the extended hours and out of hours service was provided to patients.

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 and the practice manager was the responsible person who handled all complaints in the practice.

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. Both of these had been reviewed in April 2014. The procedure reflected the

Are services responsive to people's needs?

(for example, to feedback?)

requirements of the NHS complaints process and included the details of external bodies for complainants to contact if they preferred. This process was included in the practice information leaflet and on the practice website for patients.

We saw a complaints log and asked to see a random selection of complaints. All of these showed that they had been investigated and resolved to a satisfactory outcome.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear vision to place patients' needs at the heart of everything it did. One of the partner GPs was the lead for planning and was given protected time to carry out this role. Staff were all aware of the vision and values of the practice and knew what their responsibilities were in relation to these. Observing and speaking with staff and patients we found the practice demonstrated a commitment to compassion, dignity, respect and equality. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice and all the GPs met every morning before surgery and again at lunchtime to review and plan their day.

Governance arrangements

Governance arrangements were effective. Practice staff were clear about what decisions they were required to make, knew what they were responsible for as well as being clear about the limits of their authority. They all told us they felt valued, well supported and knew who to go to in

the practice with any concerns. The practice ensured that any risks to the delivery of high quality treatment were identified and mitigated before they became issues which adversely impacted on the quality of care. We saw a number of practice protocols and policies. These were reference guides for nurses and GPs to use in the care of patients. Examples of protocols and policies seen were for complaints, recruitment, equality and diversity and training. We saw that all the protocols and policies were available on the practice library which was available to staff on all the computers in the practice.

The practice used a range of data available to them and were proactive in using this data to improve outcomes for patients and work with the local clinical commissioning group. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it in 2013/14 they had met 99.3% of the outcomes.

Leadership, openness and transparency

The GPs and practice manager told us that they advocated and encouraged an open and transparent approach in managing the practice and leading the staff teams. The GPs promoted shared responsibility in the working arrangements and commitment to the practice. For example, the individual areas of responsibility included dermatology, clinical commissioning, safeguarding and hospital admissions.

Team social occasions, attended by all the staff, were regularly held to promote a group ethos. Staff we spoke with told us that they felt there was an open door culture, that the GPs and practice manager were visible and approachable. They also said that there was a good sense of team work within the practice and communication worked well. The patient satisfaction survey further illustrated the practice ethos of a caring and quality service provided for patients. There was an open culture among colleagues in which they talked daily and sought each other's advice.

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

The practice had gathered feedback from patients through the National Patient Survey, Patient Participation Group (PPG) surveys and compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area and on the website. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings. We reviewed the results of the GP national survey, published in January 2015, and noted 96% of patients described their overall experience of the practice as good.

The practice had PPG which was made up of a diverse range of patients. The PPG met quarterly to review the findings from surveys and to discuss ways in which patient experience could be improved. The practice made available to patients a newsletter, providing patients with updates such as changes to appointments and how to take part in the friends and family test. Action plans developed by the PPG were available on the practice website.

All of the staff we spoke with told us they felt included in the running of the practice. They went on to tell us how the GPs and practice manager listened to their opinions and respected their knowledge and input at meetings. We were told that staff turnover and sickness was low and many staff had worked at the practice for over 10 years. Staff told us they felt valued and were proud to be part of the team.

Are services well-led?

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They also told us that regular appraisals took place.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place and improvements were made. The practice completed reviews of these and shared information with staff via meetings. Actions included how the practice could improve outcomes for patients.

Clinical audits were instigated from within the practice or from safety alerts received. We looked at several clinical audits and found they were commenced however not all demonstrated a full audit cycle.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment A fridge which was used to store medicines and vaccinations did not work effectively. Temperatures rose above the recommended range overnight on a number of occasions. This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person must – Ensure equipment is properly maintained and suitable for the purposes of the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Staff that performed chaperone duties did not have either a DBS check or documented rationale why such a check was not required. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person must – Ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Risk assessments had not been carried out for fire safety and legionella and emergency medicines storage. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person must –

Identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying out of the regulated activity.