Westongrove Partnership - Wendover Health Centre

Quality Report

The Health Centre
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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 inspected Wendover Health Centre part of the Westongrove Partnership on 11 December 2014. This was a comprehensive inspection. The practice has two other registered locations which were not inspected as part of this inspection.

We have rated the practice as good, although improvements in safety, specifically medicines management are required.

Our key findings were as follows:

The practice provided good care and treatment to its patients. National data showed the practice performed well in managing long term conditions. Patients reported that they could access the practice and the system of phone triage worked well (the triage system was usually a phone consultation with a GP to determine what assistance a patient needs). The premises were accessible, clean and safe. There were some areas of medicines management which required improving, specifically storage and monitoring of medicines. Staff were aware of the needs of their patients including small numbers of vulnerable patients such as those who were homeless or travellers. The practice was responsive to potentially vulnerable patients. There were clear leadership structures and an open culture which was inclusive and encouraged staff to participate in the running of the practice. Patients were consulted to assist the leadership in making improvements to the service.

We saw three areas of outstanding practice these were:

- Robust assessments of vulnerable patients were undertaken in order to ensure the needs of vulnerable groups were understood and met. This included training staff in the needs of patients with autism and ex-service personnel.

Summary of findings

- A 'friends service' was in place at the practice to provide support to vulnerable patients such as those who were housebound. The 'friends' service' had a desk open to patients in the waiting area of the practice for up to four hours each day.
- the practice was trying to provide local travellers, who may not have been registered with a practice, with medical records where these were missing. This would enable the practice to provide care planning for these patients, where necessary, and a better continuity in their care.

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

Importantly, the provider must:

- Review protocols and risks associated with medicines management including group directives to ensure staff are administering vaccines in line with national guidance, arrangements for emergency medicines to ensure staff could access these if required and assess and manage the risk of un-authorised persons accessing the dispensary.

In addition the provider should:

- undertake a legionella risk assessment.
- ensure all information required is available in regards to staffing checks and recruitment.
- ensure audits are collated in one place for all staff to access.
- consider the patient feedback from the national patient survey 2014 particularly regarding involvement in care decisions.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Staff showed an awareness of and had access to safeguarding protocols. They were proactive in reporting any safeguarding concerns. Medicines were not always stored safely or ordered in line with national requirements. Emergency medicines were available but greater clarity was required as to where they were stored in case staff needed to locate them in an emergency.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average nationally. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Clinical leads provided GPs and nurses with specialists support in meeting patients' needs. There was a robust system of audit which usually translated into real changes to improve patients' care and learning outcomes. Health information was promoted. There were appropriate consent arrangements including awareness of the Mental Capacity Act 2005. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice appraised staff, provided a mentoring scheme to GPs and had personal development plans for all staff. Staff worked with multidisciplinary teams in planning and delivering patient care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for certain aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with local stakeholders to secure service improvements. The extent of local vulnerable patients and their needs was understood and assessed to ensure the service could deliver the care and treatment they required. Patients told us they could get an appointment and there was a system to get a same day appointment with a named GP. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly and robustly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy including plans to meet the future demands on the service and how to improve the care of those who most needed primary healthcare. 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 held regular governance meetings. There were 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 (PPG) 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 that outcomes for patients were good for conditions commonly found in 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, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice cared for patients in 14 local care and nursing homes and had specific measures for ensuring these patients' needs were met. Safeguarding vulnerable adults was at the core of delivering care and treatment and on occasions when staff were concerned about patients' safety alerts had been made to appropriate bodies. Seventy eight per cent of patients over 65 received a flu vaccination which was higher than the national average. Home visits were available when needed. Over 30% of same day appointments were allocated for named GP appointments to provide patients an appointment with their preferred GP when needed.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients with long term conditions were prompted to visit the practice and could call a dedicated phone line for booking long term condition check-ups. Over 30% of same day appointments were allocated for named GP appointments to provide patients an appointment with their preferred GP when needed. National data showed patients with chronic conditions were well cared for. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. There were designated clinical leads for different chronic diseases such as diabetes. Flu vaccinations were delivered to 62% of patients under 65 in at risk groups which is significantly above the national average. The practice had identified the smoking status of 95% of patients with physical or mental health conditions and 91% were offered smoking cessation support. Patients being assessed for hypertension were offered off-site monitoring equipment to provide more accurate and better monitoring of hypertension.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Safeguarding children awareness among staff and protocols were robust and the practice was proactive in reporting any safeguarding concerns. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group of patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The appointment system was popular with patients and they reported good access including the ability to have phone consultations with GPs. There was a protocol for ensuring that university students returning home were able to access the surgery via a temporary registration. Travel clinics were available to patients who needed travel advice or vaccinations. The practice's performance for cervical smear uptake was 80% over the last five years.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. There had been a robust assessment of the differing needs of patients in vulnerable circumstances including the small numbers of homeless patients and travellers. There was an audit of ex-service personnel who may experience specific health problems to assess how well the practice was meeting their needs. A 'friends service' was in place at the practice to provide support to vulnerable patients such as those who were housebound and living in isolated areas. They provided services such as delivering medicines, specifically to those living in rural areas. The practice kept a register of all patients with learning disabilities these patients were offered an annual physical health check.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good 

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Those experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had identified the smoking status of 95% of patients with mental health conditions and 91% were offered smoking cessation support.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 792 patients undertaken by the practice. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed 85% of practice respondents said GPs were good at listening to them and 78% of nurses were good at listening to them. The survey also showed 86% said the last GP they saw and 81% said the last nurse they saw was good at giving them enough time. These results were slightly below the regional average. The practice received positive feedback regarding how GPs and nurses treated patients with care and concern and this was above the regional average.

Patients completed CQC comment cards to provide us with feedback about the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

Areas for improvement

Action the service MUST take to improve

- review the patient group directives to ensure staff are administering vaccines in line with national guidance
- review the arrangements for emergency medicines

Action the service SHOULD take to improve

- Risk assess the access of un-authorised persons to the dispensary
- undertake a legionella risk assessment
- ensure hygiene and infection control audits are acted on and that monitoring of cleaning if effective
- ensure all information required under the regulations (Schedule 3) is available in regards to staffing checks and recruitment
- ensure audits are collated in one place for all staff to access.
- consider the patient feedback from the national survey 2014 particularly regarding involvement in care decisions

Outstanding practice

- Robust assessments of vulnerable patients were undertaken in order to ensure the needs of vulnerable groups were understood and met. This included training staff in the needs of patients with autism and ex-service personnel.
- A 'friends service' was run at the practice to provide support to vulnerable patients such as those who were housebound. The 'friends' service' had a desk open to patients in the waiting area of the practice for up to four hours each day
- the practice was trying to provide local travellers, who may not have been registered with a practice, with

medical records where these were missing. This would enable the practice to provide care planning for these patients, where necessary, and a better continuity in their care.

Westongrove Partnership - Wendover Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, two registered nurses with experience in practice nursing, a practice manager, a pharmacist inspector and an expert by experience.

Background to Westongrove Partnership - Wendover Health Centre

The Westongrove Partnership has a patient population of approximately 27,000 patients. We carried out an announced comprehensive inspection of the practice on 11 December 2014. We visited Wendover Health Centre during this inspection. This was the first inspection of the practice since registration with the CQC. The practice was located over three registered locations, the other sites were Bedgrove Surgery, Aylesbury, HP21 7TL and Aston Clinton Surgery, Aston Clinton, HP22 5LB. We did not visit the other registered sites as part of the inspection. Wendover Health Centre is a purpose built surgery. Patient services were located on the ground floor with administration on the first floor. Adaptations have been made to ensure the practice is accessible for wheelchair users. The local community has an older population and the staff were aware of the needs of this section of the population. There were some small sections of ethnic minorities within the local community and patients in vulnerable circumstances. The appointment system allowed appointments to be booked in advance or on the same day and phone consultations were offered. Appointments with named GPs were also available on the same day if patients needed them. Patient feedback showed staff were very caring, friendly and considerate. The practice virtual patient participation group is involved in the running of the practice and has influenced changes to the practice.

We spoke with eight patients during the inspection. We also spoke with GPs, trainee GPs, nurses, various members of the management team, administration staff and dispensary staff.

There were 11 GP partners and a total of 26 GPs working at the partnership across the different practice sites. There was a mix of male and female GPs. The nursing team consisted of practice nurses and health care assistants. Administrative and reception staff also worked at the practice. Westongrove Partnership is a training practice.

The practice has a Primary Medical Services (PMS) contract. PMS contracts are subject to local negotiations between NHS commissioners and the practice.

This was a comprehensive inspection. We visited Westongrove Partnership Wendover Health Centre, Aylesbury Road, Wendover, HP22 6LD as part of this inspection.

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the website.

Detailed findings

Why we carried out this inspection

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

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

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

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Buckinghamshire Healthwatch, NHS England and Public Health England. We visited Wendover Health Centre on 11 December 2014. During the inspection we spoke with GPs, trainee GPs, nurses, various members of the management team, administration staff, dispensary staff and patients. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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 patients' needs?
- Is it well-led?

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

- Older patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients living in vulnerable circumstances
- Patients experiencing poor mental health (including patients with dementia)

The practice was in an area of low economic deprivation and significantly older population. The estimated levels of long term conditions such as hypertension, cardiovascular disease and respiratory diseases were above national averages. There were patients living in isolated areas surrounding the practice.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national medicines alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff had access to significant event forms and they knew where to access them.

We reviewed complaints, significant events, minutes of meetings and discussed incidents with staff which had led to action to protect patients from harm. This showed the practice had identified and managed risks to patients consistently.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last year. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We saw significant events were identified from a number of sources including complaints. The noted investigations into significant events were detailed and thorough. For example, where complaints about alleged misdiagnoses were made GPs looked in detail into patients' consultations and other relevant notes in their records to deduce if the practice had missed any anything and whether there was any learning from the complaint.

We saw the system used to manage and monitor significant events. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, such as specific training provided to staff resulting from a complaint. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. The practice had raised two safeguarding referrals within the last year where staff had identified concerns with patients' welfare or safety that potentially required intervention from an appropriate body, such as the police or safeguarding authority.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the safeguarding lead was and who to report to in the practice if they had a safeguarding concern.

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 children subject to child protection plans or if an adult was vulnerable. Reception staff were provided with awareness on how to support vulnerable patients safely, such as those who were deaf or disabled. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Staff were aware of how to identify vulnerable children and adults and records demonstrated liaison with partner agencies such as the police and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All staff who performed chaperone duties had been trained to be a chaperone.

Are services safe?

Medicines management

We looked at all areas where medicines were stored and spent time observing dispensary processes and procedures. We looked at records including audits and operating procedures. We also talked with staff and patients. The practice dispensed medicines as some of the patient population lived in remote areas and may not have been able to easily access a pharmacy. The dispensary was always staffed with two trained dispensers and was open every week day and Saturday mornings. We saw how they managed the repeat prescriptions for Wendover Health Centre and how they ensured the GPs checked and signed the prescriptions before dispensing medicines. We heard from patients that there was no delay in obtaining their repeat prescriptions and dispensary staff said that a voluntary service supported by the practice delivered medicines to isolated and potentially vulnerable patients.

We looked at the security of medicines. All refrigerated medicines such as vaccines were kept in locked fridges and temperatures were monitored to maintain cold storage and their potency. We observed that the door to the dispensary was unlocked and although inaccessible to patients, cleaners and practice staff could gain access when dispensary staff were not on site. There was a risk that unauthorised staff could have access to medicines. Controlled drugs (medicines requiring special storage were secured in an appropriate cupboard meeting legal requirements. Records of receipts and balances of stock were kept for controlled drugs and there were regular checks by practice staff, the police and the Clinical Commissioning Group.

We saw prescriptions pads were stored securely so that they could not be removed by anyone other than authorised staff. We asked dispensary staff about errors and saw their recording of errors and near misses. The records included action taken when errors occurred so that they did not happen again. We talked to two GPs and the audits they were involved with. Some were initiated by the practice and others by the CCG, which were based on prescribing data and national guidance. All errors in prescribing were discussed as serious incidents at practice level. We saw the comprehensive standard operating procedures for staff to follow and the audits carried out by the CCG and GP with overall responsibility for the dispensary.

Dispensing staff had received training and we heard from the site manager that they had annual assessments of their competency. There was a lead prescribing GP and a GP responsible for the dispensary. A GP supervised the training of the dispensary staff and they were invited to the monthly protected learning meeting each month. The practice was supported also by a pharmacist from the CCG who visited the practice once a week and was involved in medicine reviews in the care homes supported by the practice. The practice carried out routine vaccinations and nurses gave several injections under patient group directives. We found that only a few of these had been signed by the practice governance lead and those nurses deemed competent to administer the appropriate injection. Nurses were, therefore, not authorised to give these injections.

Cleanliness and infection control

We observed the premises to be mainly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw dust on skirting and trolleys in some treatment rooms. However, practice was undergoing building work which may have attributed to this.

The practice had a lead for infection control. Staff received training about infection control specific to their role and received updates. We saw an audit from July 2014 which identified a number of areas for improvement to ensure patients and staff were protected from any infection risks. Some of the actions were completed such as purchasing disposable curtains for treatment rooms. We noted that some actions had not been taken over four months since the audit such as providing a separate room for disposing of samples. This issue was a potential risk to infection control as there was only one in a sink in a treatment room which meant patient samples and potentially clinical waste would be disposed of in one sink which was also a hand wash sink. The site manager and nurses told us there was a plan to implement all the measures to improve infection control and this was one issue noted on the audit plan. Some of the actions from the audit were linked to building work underway and were therefore in the process of being completed. The practice had re-audited infection control in November 2014 to assess progress made since the initial audit. We saw a pillow in a treatment room had been ripped and mended instead of being disposed.

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and there had been two instances of such injuries in 2014. From reviewing significant event investigations we saw the policy was followed. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A risk assessment had, therefore, not been undertaken.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw all equipment was in working order and well maintained. A schedule of testing was in place. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, administration staff did not have proof of identification on their staff files.

There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place to ensure that enough staff were on duty and to reduce the need to bring in auxiliary staff such as locum GPs. Partners told us there had been minimal use of locum GPs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and 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. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and risk assessment which was updated annually. Health and safety information and training was provided to staff. There was a fire risk assessment in place as well as checks of fire safety equipment and fire safety training for staff. There was a control of substances hazardous to health (COSHH) risk assessment available within the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

The surgery had a supply of medicines for use in an emergency and these were signposted throughout the practice. We saw a list of the medicines available in a clinical room where vaccines were given (some emergency medicines may be required if patients have an adverse reaction to a particular vaccine). When we looked at the emergency trolley not all emergency medicines that could potentially be required for the administration of vaccines were available. We saw two GP's bags containing emergency medicines and these were checked monthly by the dispensary staff. Signs in the practice informed staff where emergency medicines were stored. However, we found some emergency medicines were stored in different areas of the practice meaning some staff may not know where they were located.

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. Relevant contact details were available in the plan related to various scenarios where assistance would be required to support staff in managing emergencies.

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 approaches to treatment. They were familiar with current best practice guidance, and accessed 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 practice regularly reviewed its procedures for caring with specific conditions to ensure that patients' care and treatment was effective. For example, we spoke with the GP diabetic lead who informed us the way diabetic care was delivered had been reviewed and was going through changes to improve the care for diabetic patients. The changes were being monitored and the GP was able to inform us of improvements to diabetic reviews as a result of the changes. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Patient recalls for reviews of their conditions were managed through a system where patients were prompted to visit the practice and could call a dedicated phone line for booking long term condition check-ups.

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. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to discuss individual concerns about patients with the diabetic lead. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice reviewed patients recently discharged from hospital. The practice also undertook an enhanced service to reduce the risk of patients requiring admissions to hospital. Those patients identified as being at risk had detailed care plans in their records and were visited by the practice when they were deemed at significant risk of requiring a hospital admission, due to ill-health or personal circumstances.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Regular reviews of elective and urgent referrals were made during clinical meetings so that learning could be shared with all staff. This also identified where the practice could refer patients to GPs with specialisms to prevent some patients having to use secondary care.

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 treated or referred on need and that age, sex and race was not taken into account in this decision-making. The practice had been proactive in ensuring the services it provided were planned with the needs of local patients who may be vulnerable, such as homeless patients or those suffering from mental health problems. For example, staff told us the practice was working towards creating patient records for all the travellers who used the practice to provide them with consistency in their care, and where necessary, care planning.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, dispensing medicines, managing child protection alerts and medicines management.

There was a broad spectrum of clinical audits being undertaken at the practice. The practice showed us approximately 12 audits that had been undertaken in recent years. The audits we looked at included mistyped notes, osteoporosis, dermatology referrals and inhaled steroid use. Nearly all of the audits we saw were completed audits where the practice was able to demonstrate the changes resulting since the initial audit and showed where improvements were made. We saw evidence that the audits had been presented at practice meetings. Although most audits were shared for learning outcomes to be shared with all staff, some audits were not collated in one place for all staff to access.

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). QOF is a national performance

Are services effective?

(for example, treatment is effective)

measurement tool. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example QOF data indicated that patients with diabetes were being managed well and had an annual health check and medication review. This practice was not an outlier for any QOF clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. Nurses took part in some clinical audits and they were informed of audit outcomes.

There was a protocol for repeat prescribing which was in line with national guidance. Staff followed the protocol to regularly check that patients receiving repeat prescriptions had been reviewed by the GP. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial, dispensing and administrative staff. We reviewed staff training records and saw that all staff received a broad range of training including mandatory courses such as annual basic life support. Some staff were not up to date with their training as per the intervals indicated on the training log. GPs told us they managed their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP for support. We received positive feedback from the trainees we spoke with. The practice operated a GP mentoring scheme where GPs met monthly for half an hour with their mentoring groups of two to three GPs to discuss issues and support. They also had informal arrangements to discuss concerns with their mentors when needed. We saw appointments were blocked out to ensure the monthly mentoring meetings took place.

Practice nurses were expected to perform defined duties and told us that they were trained to fulfil these duties. For example, on administration of vaccines and diabetic care.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Where any instances occurred where information was not received from hospitals such as changes to prescriptions the practice recorded the issues and reported them appropriately once they identified the concerns.

The practice worked with 14 local nursing and care homes to ensure that patients' reviews and check-ups took place regularly. This included systems for gaining information relevant to QOF for updating patient records. For example, patients' weights may be sent to the practice directly from a nursing or care home to update patient records without a visit being required to the homes.

The practice held multidisciplinary team meetings with external professionals regularly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses. Staff felt they worked well with external care and health services and believed information was shared constructively to ensure patients were well cared for.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making

Are services effective?

(for example, treatment is effective)

referrals. The practice made use of the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system called Emis web to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For scenarios where a patient's capacity to make decisions was potentially in question, the practice had drawn up a policy to help staff. This policy included the principles of the MCA 2005 including when and how a patient's capacity can be assessed. We saw that a patient with dementia had notes made by a GP in their records stating how the patient could be supported to make decisions and their ability to consent, including that this may be change over time and depending on the decision being made.

Patients told us they were involved in decisions about their care and treatment, including referrals. Feedback from the national patient survey suggested GPs were involving patients in decisions about their care and treatment. However, the survey results showed patients felt nurses did not always do so.

Health promotion and prevention

NHS Health Checks were offered to patients aged 40-75. A programme of vaccinations including flu and child immunisations was provided. Seventy eight per cent of patients over 65 received a flu vaccination and 62% of patients under 65 also in at risk groups received them. Both of these achievements were above the national average and for the under 65s this was significantly higher. The practice achieved close to the national average for child immunisations. Travel clinics and vaccinations were available to patients.

The practice had identified the smoking status of 95% of patients with physical or mental health conditions and 91% were offered smoking cessation support. The practice's performance for cervical smear uptake was 80% over the last five years. Patients being assessed for hypertension were offered off-site monitoring equipment to provide more accurate and better monitoring of hypertension. Long term care planning was provided to patients with dementia.

The practice had numerous ways of identifying 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 these patients were offered an annual physical health check.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 792 patients undertaken by the practice. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed 85% of practice respondents said GPs were good at listening to them and 78% of nurses were good at listening to them. The survey also showed 86% said the last GP they saw and 81% said the last nurse they saw was good at giving them enough time. These results were slightly below the regional average. The practice received positive feedback regarding how GPs and nurses treated patients with care and concern and this was above the regional average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect. We also spoke with approximately eight patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We saw no evidence that patients experienced any kind of discrimination.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We observed staff were careful to protect patients' confidentiality. For example, reception staff were careful to prevent patients overhearing potentially private conversations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with felt involved in planning and making decisions about their care and treatment and generally rated the practice well in these areas. However, only 64% of patients said nurses and 68% said GPs were good at involving patients in care or treatment decisions on the national patient survey (below the local average). Patients felt involved in decisions about referrals which they said were explained clearly. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language and patients would be offered this service to ensure they could access the service independently.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice. Notices in the patient waiting room, on the TV screen and patient website signposted patients to a number of support groups and organisations, such as dementia and carer support. Staff we spoke with told us that they would refer to this information if they felt patients needed external support services. The practice's computer system alerted staff if a patient was potentially vulnerable. Receptionists we spoke with were aware of how to support patients who were deaf, a carer, had dementia or a learning disability.

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 had systems in place to review, maintain and where possible improve the level of service provided. This included responding to the needs of very small sections of the patient population such as those who do not speak English or homeless patients. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice served a large population of current and ex-service personnel and had undertaken an audit of ex-service personnel who may experience specific health problems to assess how well the practice was meeting their needs. The practice took steps to ensure that homeless patients could access services even if they were not registered with the practice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and the patient participation group (PPG). Due to having a large proportion of registered patients over 65 years of age and due to patient feedback, the practice had identified that seeing a named GP was important to their local population. The appointment system was altered to keep one third of appointments for patients to be able to see their named GP the same day if they requested. This increased the opportunity for patients to see their GP which was popular with patients and potentially meant that continuity in care was improved for some patients with specific conditions.

The practice had produced a 'how to' leaflet to provide information to patients on how to access services within the practice. A 'friends service' was run from the practice to provide support to vulnerable patients such as those who were housebound. The 'friends' service' had a desk open to patients in the waiting area of the practice for up to four hours each day. They provided services such as delivering medicines to those who were isolated, specifically those living in rural areas. There was a protocol for ensuring that university students returning home were able to access the surgery via a temporary registration.

Patients could book reviews of their long term conditions via a designated phone line and booking system. This enabled patients to book directly through the phone line or be called back to book their appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff told us about the extent of vulnerable sections of the community, such as homeless patients and travellers. Even though the proportion of both these groups was very low the practice had considered the needs of these patients and planned the service to ensure these patients could access the practice. For example, the practice was trying to provide local travellers, who may not have been registered with a practice, with medical records where these were missing. This would enable the practice to provide care planning for these patients, where necessary, and a better continuity in their care.

The practice had access to a telephone translation services and a GP who spoke a foreign language which supported some patients who did not speak English.

The practice provided equality and diversity training through online learning. The premises and services had been adapted to meet the needs of people with disabilities, patients with buggies and prams and those with limited mobility. Automatic doors and level access were available. Consultation and treatment rooms were on the ground floor with wide corridors and doorways. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Wendover Health Centre was open between 7.30am and 6.30pm Monday to Friday. Extended hours were available on Tuesdays until 8pm. Saturday morning pre-bookable appointments were also available from 8.15am to 11.00am. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. The practice had a duty GP available Monday to

Are services responsive to people's needs?

(for example, to feedback?)

Friday with no appointments booked. This enabled the duty GP to speak with patients who required a telephone consultation or those just seeking advice. The practice operated a telephone clinical assessment system for booking appointments. Patients told us this system worked well.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to 11 local care homes on a regular basis, by a named GP and to when patients needed one.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were displayed and available to patients through a leaflet. We looked at complaints received within the last 12 months and found these were satisfactorily handled, investigated robustly with openness and transparency and patients were responded to. The practice reviewed complaints regularly to identify learning outcomes and where necessary these were shared with staff. Training needs were identified through complaints. For example, a patient complained that GPs lacked awareness about autism following a consultation and as a result of this complaint the practice was delivering autism awareness to nurses and GPs and involved the family of the patient in the training.

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 deliver high quality care and promote good outcomes for patients. There was a core principle of learning for all staff embedded into the culture of the practice. This was reflected in the way the practice responded to patient feedback and incidents which identified learning outcomes. The practice continually enhanced staff awareness to enable them to perform their roles and improve the services provided. The leadership team considered and strategically planned how it could improve. For example, a new scheme was being planned called the 'Weston project' to pre-empt medical crises and reduce hospital admissions for patients over 75. Working closely with other agencies, it was to be a nurse led service, with a GP and two care coordinators who will work together. The plan included training nurses to fulfil extended clinical role including diagnoses and examinations in the community. Quality assessment was being planned for the project to measure its impact.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Staff we spoke with knew where to find these policies if required. We looked at several policies and procedures including safeguarding vulnerable adults and children, whistblowing and the business continuity plan. There was a system to ensure the policies and procedures were reviewed and amended when necessary.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. The practice had an extensive programme of clinical audits which it used to monitor patient outcomes and the use of best clinical practice. Where improvements were identified there was action taken to improve the service. We saw audits were completed, in that they were repeated to ensure that any action required was achieved. The diabetic lead informed us of a programme to improve diabetes reviews and the ongoing monitoring and audit of this programme meant staff knew it was working well. Nurses were involved in undertaking audits.

The practice had arrangements for identifying, recording and managing risks. For example, the practice had risk assessments for control of substances hazardous to health (COSHH) and fire safety. The fire risk assessment had an action plan for managing and minimising fire risks. The practice held regular meetings which including governance. There was no legionella risk assessment.

Leadership, openness and transparency

Staff told us they all had opportunities to attend team meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or with their line managers. They told us they felt well supported. For example, the nursing team told us they felt well supported by their team lead. Staff were proud to work at the practice and there was a low turnover of staff and minimal usage of agency staff such as locum GPs.

There was a management team which consisted of a general manager, operations manager, managing partner, finance Manager and nurse manager. There was also a site manager based at each of the sites. They had a clear structure and systems to manage different aspects of the practice such as human resources and building maintenance. There was a staff handbook for reference and to support staff.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, complaints and comments received. The patient survey identified a number of areas the practice could make changes based on patients' views. This included changing the information displayed in the waiting area and piloting a text messaging service for patients to enhance communication.

The practice had a virtual patient participation group (PPG) which had steadily increased in size. There were currently 163 members of the PPG and they carried out quarterly

Are services well-led?

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

surveys. The analysis of the patient surveys and resulting action plans were consulted with the PPG to agree a final plan every year. The results and actions agreed from these surveys were available on the practice website. The practice had received some low scores in the national GP survey regarding the involved in patient decisions specifically regarding nurses. We asked GP partners if they had considered why this feedback was low but they told us the results had not been discussed at any governance meetings. This may have identified an issue with how appointments were organised or potentially a staff training issue.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff electronically via the intranet.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days and internally had guest speakers and trainers to supplement their learning and development.

The practice was a GP training practice and trainee GPs felt well supported to undertake their roles and training. GPs had a mentoring scheme which enabled them to share concerns regularly with other GPs.

The practice had completed reviews of significant events, complaints and other incidents and shared with staff at meetings and disseminated through line managers to ensure the practice improved outcomes for patients. We saw significant events were analysed robustly to ensure that any issues with protocols or staff awareness were identified and acted on.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **There were not appropriate arrangements in place for obtaining, recording, handling, using, keeping safe and dispensing of medicines.** **Regulation 13.**