University Health Service

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at University Health Service on 9 April 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing responsive, caring, well-led and effective services for 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 and addressed but monitoring of learning was poor.
- Risks to patients were assessed and managed, with the exception of those relating to emergency medicines management and staff recruitment.
- Information sharing and auditing was informal and records were not always kept.
- The systems and arrangements for governance were not always in place and so staff may not have all the required information for their roles.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management.
- 90% of respondents to a national patient survey said their overall experience of the practice was good.
- Quality and outcome framework data for this practice in 2013/14 showed it had met 97.9% of the outcomes. This was higher than the national average of 94.2% for GP practices.

Summary of findings

The areas where the provider must make improvements are:

- Ensure emergency medicines are available, fit for purpose and within the expiry date;
- Ensure staff recruitment checks are completed in full; and
- Carry out a risk assessment to identify those who require a DBS.

Action the provider SHOULD take to improve:

- Identify, manage and monitor effective infection prevention and control systems;
- Carry out staff appraisals in a timely manner; and
- Review practice policies to ensure they are up to date.

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 their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough. Lessons learned were not communicated widely enough to support improvement. Although some risks to patients who used services were assessed, the systems and processes to address these, risks were not implemented well enough to ensure patients were kept safe. Areas of concern included, recruitment checks, infection control and emergency medicine management.

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. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Significant events were taken seriously and responded to in a timely manner. Patients' needs were assessed and care was planned and delivered in line with current guidance. This included assessing capacity and promoting good health. Not all staff had received training appropriate to their roles.

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 several 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 for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. 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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Complaints we looked at were investigated to a satisfactory conclusion for the patient.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had 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 staff felt supported by management.

The practice proactively sought feedback from patients and had an active virtual patient participation group. There was evidence of appraisals and personal development plans in place for some staff but gaps were found for administration and practice management. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. There was also a limited number of systems in place to monitor and improve quality and identify risk.

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 older people.

The practice offered 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 part funded a nurse with two other local practices to help care for patients aged 75 and over who provided an assessment service either in the practice or at home as required.

Whilst the practice only had a 66 patients aged 75 and over. Each patient had a named, GP who provided a personalised, tailored service to the patient. For example, some GPs visited patients while they were in hospital. Care plans were offered for patients aged 75 and over to try to avoid unplanned hospital admissions. Home visits were carried out for housebound patients and the clinical staff liaised with carers where appropriate. Some patients also had a direct contact number for the reception office manager who would assist with many and varied queries which were not always health related.

People with long term conditions

Good

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

Longer appointments were available on patient request and GPs assessed and treated all patient's needs in a single consultation to avoid them returning for further appointments. 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 to provide continuity of care and avoid hospital admissions.

Opportunistic health checks were carried out for patients seeing the nurse or health care assistant for other reasons. Checks included height, weight and blood pressure. The administration team recalled patients with long term conditions and also those on medicines that required special monitoring to ensure that they had all the relevant blood tests. The practice achieved maximum points on the quality register in this area. A recent diabetes audit identified the practice as providing one of the highest levels of service in the local clinical commissioning group area for patients with this condition.

Summary of findings

Families, children and young people

Good

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

Three GPs offered obstetric appointments and children were always seen on the same day in duty clinics. The practice had a recall system for six week checks for new born babies and patients were followed up if they did not attend (DNA) appointments. All families were asked to complete a 'supplemental registration form' which detailed all persons living at the household to assist in safeguarding.

The practice achieved 90% in childhood immunisation targets, and it ran mainly set clinics but very often booked patients outside of these to accommodate the child's parent who worked or had home commitments. The nurse running the immunisation clinic called parents personally if a child did not attend. If there were two or more appointments missed then the matter was highlighted to the practice safeguarding lead and the child's records were coded accordingly.

A dedicated member of the administration team completed searches periodically and sent out letters/telephone calls/emails to parents of newly registered children when there wasn't any immunisation history and if they hadn't had all their immunisations according to the UK schedule so information could be provided to update the child's record.

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 practice offered telephone consultations face to face appointments, some email based consultations and patients could book appointments on-line using Patient Access. Choose and book systems for secondary care referrals was available which allowed patients to book their hospital appointments around their lives.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Patients who lived out of the area could register with University Health Service under the 'Choice of GP' scheme. The practice offered text message reminders to patients for booked appointments and also a facility for patients to cancel their appointments by text.

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.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice worked closely with the University and medical school to support vulnerable students. Visits were made to vulnerable housebound patients. If a patient who was homeless wanted to register, staff would, in the first instance, direct them to the Homeless Health Care Team who specialised in their care and rehabilitation. If a patient who was registered with the practice became homeless for whatever reason, staff would endeavour to keep them on their patient list to ensure continuity of care.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia).

Patients with poor mental health were seen sometimes weekly or more, based on their need. Daily and weekly prescriptions were given if required and patients were not removed from the practice list if they moved outside the area (at GP request) so as not to destabilise their treatment for their mental health. Patients were given longer appointments by default and reception staff knew them all very well and would always give an appointment on the day if they request this. GPs attended multidisciplinary meetings as requested and reviewed patients' mental capacity as required. The practice had a register of patients with mental health diagnoses and those living with dementia and an annual review was offered routinely. It also carried out advance care planning for patients living with dementia.

Summary of findings

What people who use the service say

We received 13 completed patient comment cards and asked 19 patients for their views of the service at the time of our inspection visit. These patients included older patients, mothers with babies, vulnerable patients and patients of working age.

The majority of patients we spoke with and who completed Care Quality Commission comment cards were very positive about the care and treatment provided by the GPs and nurses and other members of the practice team. Everyone told us that they were treated with dignity and respect and that the care provided by the GPs, nursing staff and administration staff was of a very high standard. Comments included reference to GPs and staff being very professional, caring, attentive and welcoming.

The practice had a virtual patient participation group. This group was a way for patients and the practice to listen to each other and work together to improve services, promote health and improve the quality of care.

Results of surveys were available to patients on the practice website alongside the actions agreed as a result of the patient feedback.

We also looked at the results of the 2014 GP patient survey which was published in January 2015. This was an independent survey run by Ipsos MORI on behalf of NHS England. The survey showed that the practice achieved better than average results for the local area and nationally, these results included;

- 78% of respondents said their experience of making an appointment was good
- 81% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care
- 82% of respondents said they were satisfied with the practice's opening hours
- 87% of respondents said they would recommend the practice to someone new to the area
- 90% of respondents said their overall experience of using the practice was good.

Areas for improvement

Action the service MUST take to improve

- Ensure emergency medicines are available, fit for purpose and within the expiry date;
- Ensure staff recruitment checks are completed in full; and
- Carry out a risk assessment to identify those who require a DBS.

Action the service SHOULD take to improve

- Identify, manage and monitor effective infection prevention and control systems;
- Carry out staff appraisals in a timely manner; and
- Review practice policies to ensure they are up to date.

University Health Service

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

The team included a GP specialist advisor and practice manager specialist advisor.

Background to University Health Service

University Health Service is a purpose built GP practice situated in the grounds of Southampton University, Highfield, Southampton. It has been based in its current location since 1992.

The practice has an NHS general medical services (GMS) contract to provide health services to approximately 15,100 patients.

University Health Service opens from 8.00am to 6.30pm Monday to Friday and appointments are available on these days between 8.00am and 5.30pm. The practice has opted out of providing out-of-hours services to its patients and refers them to HDoc's and Care UK out-of-hours service via the 111 service.

The practice has a high number of patients (approx. 9500) who are students studying at Southampton University.

The practice has five GP partners and a salaried GP. In total there are three male and three female GPs. The practice also has two practice nurses and one health care assistant. GPs and nursing staff are supported by a team of 14 administration staff. The practice administration team consists of receptionists, administrators, a reception manager, a business manager and their personal assistant. University Health Service is also a training practice for medical students and doctors training to be GPs.

We carried out our inspection at the practice situated at:

University Health Service

Building 48

Southampton University

Highfield

Southampton

SO17 1BJ

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.

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.

Detailed findings

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 local 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 and NHS National GP Patient Survey.

We carried out an announced inspection on 9 April 2015.

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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety 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. One example seen was the requirement for patients to have regular blood test monitoring who were prescribed Denosumab (a medicine used to prevent bone fractures). The practice identified all the affected patients and revised its protocol to ensure they were having regular blood tests and reviews.

Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. A GP told us how they raised the issue of poor communication between a secondary care service and the practice regarding safety for patients who were insulin dependent. This was discussed at practice partners meeting and with the local clinical commissioning group. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

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 four clinical and four administrative significant events that had occurred during the last 12 months and saw this system was followed appropriately. Clinical significant events were discussed at weekly clinical meetings by GPs and nurses. Administrative significant events were discussed at business meetings. Business meetings were also attended by GPs and nurses. 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.

Staff used proforma forms which were available on the practice intranet and sent completed forms to the practice manager or GP is the event was clinical. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. Actions included the introduction of a template which was integrated into clinical records. This documented the procedure to follow as per the Faculty of Family Planning and Reproductive Healthcare guidelines and supervising clinicians directly supervised trainee GPs when performing this procedure.

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.

A GP partner was the lead for safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with 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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. For example, the safeguarding lead met with the health visitors every six weeks to discuss children who were identified as being at risk. Following these meetings patient's notes were updated to show the outcome of discussion.

The practice had a chaperone policy, which was displayed in the waiting room and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Records supplied to us before

our visit showed that four administration staff acted as chaperones. Two of these had received chaperone training in 2008. None of the four staff who undertook chaperone duties had received criminal records checks such as through the Disclosure and Barring Service (DBS) or a risk assessment documenting why such checks were not required.

Medicines management

We checked medicines stored in treatment rooms and two medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We examined two medicine/vaccination storage refrigerators and found that temperatures were monitored and recorded. Records seen showed that temperatures recorded were within the recommended range of two to eight degrees Celsius.

Processes were in place to check medicines were within their expiry date and suitable for use. Stocks of medicines/vaccinations were recorded in a stock control book and checked weekly. All the medicines we checked were within their expiry dates apart from three emergency medicines Expired and unwanted medicines were disposed of in line with waste regulations.

Fridges were services and re-calibrated annually (calibration is when equipment is checked to ensure it measures accurately). The most recent calibration was carried out in February 2015. Medicines refrigerators were sited away from treatment and consulting rooms which allowed for quick delivery of medicines and vaccinations. We found a trailing electrical supply lead to one refrigerator which could be accidently unplugged.

Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. A clear audit trail could be readily identified. All prescriptions were reviewed and signed by a GP before they were given to the patient. Signed prescriptions waiting for collection by patient's were held in a secure area of the practice away from reception and locked away over night when the practice was closed.

Nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw two sets of PGDs that had been updated on 1 April 2014.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. All of the 19 patients we asked said they found the practice to be clean and hygienic.

An infection control policy and supporting procedures dated April 2014 were available for staff to refer to, which enabled them to plan and implement measures to control infection. However, we were told the infection control policy had only recently been reviewed and had yet to be read by all relevant staff. A health care assistant was the lead for infection control and had undertaken further training in November 2014 to enable them to provide advice on the practice infection control policy. Other staff had not received infection control training, but we saw evidence that this was booked to take place within two weeks following our inspection.

The infection control policy included sharps management, storage of vaccinations and specimen handling. Staff were provided with personal protective equipment including disposable gloves, aprons and coverings and 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 staff knew the procedure to follow in the event of an injury. Sharps boxes were provided and were positioned out of the reach of small children.

The practice's new employee induction programme listed three specific infection control risks including handling clinical waste, bodily fluids and samples but other than this infection control processes were not included in the programme.

We saw evidence that an infection control audit had been carried out on 7 April 2015 and previously in October 2013. An action plan from the April 2015 audit had not been written at the time of our visit on 9th April.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, hand cleansing gel and paper hand towel dispensers were available in consulting and treatment

rooms. 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 practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the landlord of the building carried out a legionella risk assessment and regular checks to water quality were made in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Equipment included fire extinguishers which were maintained and tested yearly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was July 2014. We were also shown a test certificate which aligned with the stickers. We saw evidence that calibration of relevant equipment took place in February 2015 and included blood pressure measuring devices, weighing scales and electrocardiogram machine.

Staffing and recruitment

The practice had a recruitment and selection policy that set out the standards to follow when recruiting staff. For example, the policy stated that only after the receipt of two references and a satisfactory health record would a post be offered. The policy made no mention of any other checks required prior to a person's employment at the practice as required in the regulations. For example, proof of identity, eligibility to work in the UK and full employment history.

We looked at the staff recruitment files for a nurse and two receptionists who started to work at University Health Service in August 2013 and found that all three did not have evidence to confirm satisfactory conduct in their previous employment, a health record, full employment history or evidence of qualifications relevant to their role. The practice also had an induction policy, but there was no evidence to show that these members of staff had received an induction. A Disclosure and Barring Service (DBS) check had been carried out for the practice nurse (this check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There were no records available to confirm that the receptionists had received a DBS check or that a risk assessment had been carried out.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staffing levels were maintained during university fresher's week when approximately 2000 students registered with the practice. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The manager permitted only one staff member on leave at any time. Contracts and working hours were also arranged so there was a degree of overlap of shifts. Newly appointed staff had this expectation written in their contracts. We were told that staff worked additional hours to meet the increased demand.

Monitoring safety and responding to risk

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs, nurses and health care assistants had been allocated lead roles to make sure best practice guidance was followed in connection with patient care and treatment for example in diabetes.

A GP took the lead for safeguarding and another was the safety alert lead. Speaking with GPs, practice manager and reviewing minutes of meetings we noted safety was being monitored and discussed routinely. Appropriate action was taken to respond to and minimise risks associated with patient care and premises.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions or receiving end of life care.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all the staff had received training in basic life support in the last 12 months.

Emergency medicines and equipment were available and all staff knew of their location. Medicines included those for the treatment of cardiac arrest, anaphylaxis and

Requires improvement

Are services safe?

hypoglycaemia. Emergency equipment seen included an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm) and oxygen. All staff knew the location of this equipment and records confirmed that it was checked regularly.

Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. However, we found two epinephrine pens (for the treatment of anaphylaxis) and one tube of rectal diazepam that had passed their use by dates of March 2015 and August 2014 respectively.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety which included alarm tests and regular fire drills. Records showed that out of 21 staff 14 received fire safety training in 2013 and one received training in 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We were told that clinical meetings were held and minutes of these were taken.

The GPs told us they lead in specialist clinical areas such as diabetes, minor surgery, sports medicine, sexual health and child health surveillance and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines. For example, mental capacity act guidelines. A GP showed us notes of this meeting which they kept for their own purposes but again a formal record of this discussion was not kept.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the GPs and administration to support the practice to carry out clinical audits.

We were shown two examples of completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit was carried out to identify crossover symptoms with irritable bowel syndrome (IBS) and coeliac disease. An initial audit identified the need to increase the screening rate of all patients presenting with IBS as there was a risk of missing some cases of coeliac disease. A second audit was carried out a year later which showed an improvement in diagnostic testing for coeliac disease.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, it achieved 97.9% of the total QOF target in 2014, which was above the national average of 94.2%.

Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related and hypertension QOF indicators was better than the national average.
- The dementia diagnosis rate was above the national average

The practice's prescribing rates were also better than national figures There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. Staff also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance

was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

Effective staffing

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

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence that all staff had attended courses such as annual basic life support.

We noted a good skill mix among the GPs with a number having previous experience or qualifications in subjects that included psychosexual and sexual health, women's health (including contraceptive implants), child health surveillance and minor surgery. We were told that all the GPs were up to date with their yearly continuing professional development requirements and all either have 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).

There were arrangements in place to support professional development. These included annual staff appraisals. Records provided to us before and during our visit showed that regular appraisals took place for reception and nursing staff. We were told that administration staff's appraisals were overdue and the practice manager had not received an appraisal for over three years.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, child health surveillance and diabetes.

Working with colleagues and other services

We found the GPs, nurses 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. Health professionals included midwifes, district nurses and the community mental health team to support the needs of patients. GPs and nurses attended multi-disciplinary team meetings to ensure patient information was shared effectively.

The practice worked with other service providers to meet patient's care needs. Blood results, x-ray results, letters from the local hospital including discharge summaries, out of hour's (OOH) providers and other services were received both electronically and by post.

A designated member of staff attended to referrals via letter for patients and also arranged choose and book appointments. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff worked with the patients and GPs to ensure that choice was given through choose and book.

Emergency hospital admission rates for the practice were low (5.1%) compared to the national average (13.6%).

Information sharing

The practice shared key information electronically with the OOH service about patients nearing the end of their lives, particularly information in relation to decisions that had been made about resuscitation in a medical emergency. Likewise, patient treatment information gathered by the OOH service was shared with the practice the following morning.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local OOH service to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and OOH services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software

enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it; and had a section stating the patient's preferences for treatment and decisions. For example 100% of patients diagnosed with dementia had their care plans reviewed in the last 12 months which was higher than the national average of 83.3%.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. For example, if it was felt that a patient lacked the capacity to make decisions about their treatment. The GP referred this to social services team who carried out a mental capacity assessment for the patient, and if it was agreed, the patient had the capacity to decide and was treated as they wished. All the details were documented in their care plan.

All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an audit that confirmed the consent process for minor surgery had being recorded as being followed in 65 out of 66 cases audited.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

All new patients who registered at the practice were asked to complete a registration form and if one of the 'illness' boxes was been ticked, or if the patient was on medication, the receptionist asked them if they wish to see a GP there and then. At this time patients would be offered any relevant injections (flu, meningitis, etc.) at the time. All registrants in the appropriate age range would also be offered screening for chlamydia.

Any health concern would be dealt with by the GP at the time but if a patient was not able to see the GP, a member of the admin team coded the registration form and if anything was untoward, the patient would be invited in for a health check. For example, we were told about a teenage patient with known chronic asthma who registered during university registration week. This patient was seen by the registering GP. Their medications were added to the screen making them available for them to order when required and they were offered a flu vaccination. An Anticipatory Care Plan was shared with the Out of Hours Service and the ambulance service, letters were written to A&E, respiratory services and the Acute Medical Unit alerting them to the fact this patient was susceptible to acute deteriorations in their medical health. Alerts were added to their screen to ensure reception staff were aware that if they asked for emergency appointment this was to be offered without delay or question. Alerts were added regarding consent to share information with relevant contact (such as a family member) and under what circumstances.

Good

Are services effective?

(for example, treatment is effective)

The practice had a range of written information for patients in the waiting area and on its website, with links to local and national support groups patients could access. For example, cancer, mental health and stroke support. The practice offered a number of health promotion services which included contraception and sexual health services and foreign travel vaccination services.

The practice offered health checks to patients aged between 40 and 75. During the previous 12 months 25% of the patients who were invited came forward for a health check.

Smoking cessation support was offered to patients wished to stop smoking. Of the 997 which were identified, 897 were supported to stop smoking by attending nurse led clinics and referral to the Quitters programme. The practice was unable to tell us how many patients were reported to have successfully stopped smoking.

The practice's performance for the cervical screening programme was 67%, which was below the national average of 82%. We were told that the practice struggled to achieve the 80% target due to its diverse practice population. Patients were asked to sign an opt-out form and the practice collected data as to why they did not wish to have a cervical smear test, often this was because of cultural reasons or they had a regular smear test in their home country. When a patient registered who had previously been on the cytology recall system the practice administrative team checked the Open Exeter system for previous results. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was mixed for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 80%, and at risk groups 58%. These were above national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 84% to 95% and five year olds from 75% to 98%. These were below national averages.

Good

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, published in January 2015, a survey of patients undertaken by the practice and patient satisfaction questionnaires.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 13 completed cards and the vast majority were positive about the service experienced. Patients said they felt the practice offered a very professional service, provided excellent clinical care and were attentive and charming. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also asked 19 patients for their views about the service on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms 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 saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The waiting room and reception desk were in the same area of the practice. Staff were aware of the need for privacy and spoke softly to patients. The practice switchboard was located away from the reception desk which helped keep patient information private. There was a self-check in facility for patients to use and a room available for patients to talk to staff about confidential matters. Additionally, 92% said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 79% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 82%.
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 74% and national average of 75%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. 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. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were generally positive about the emotional support provided by the practice and rated it well in this area. For example:

- 79% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. A

Good

Are services caring?

patient told us about when they experienced a mental health crisis. They described the support they received from the practice which helped them recover. They could not emphasize enough that this would not have been possible without the support of everyone they came across who worked at University Health Service.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer or cared for.

GPs told us that due to the patient population mostly being students patient bereavements were rare but if they had a patient in this situation they would send a card to the their relative/family and offer a home visit.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, patients with young children were always given rapid appointments to address the child's health worries. This was confirmed by a patient attending the practice at the time of our visit.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. A GP was the CCG lead at the practice and attended meetings to discuss services. For example, we saw evidence of how mental health and physiotherapy services were regarded as a priority and that improvements in liaisons with the community mental health team had been made. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group. For example, the practice introduced a text message reminder service to inform patients of their blood test results.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. Access to online and telephone translation services were available for non-English speaking patients if they were needed. A number of patients were Chinese students attending the university. We were told that these and other non-English speaking patients generally attended their appointments with a translator. Registration information was available in reception and instructions written in both Chinese and English.

The premises and services had been designed to meet the needs of people with disabilities and the practice was accessible to patients with mobility difficulties. The practice consultation and treatments rooms were based on two floors. We were told that if a patient did not feel comfortable using the stairs GPs/nurses would see them on the ground floor. The consulting rooms were accessible for patients with mobility difficulties and there was a wheelchair accessible toilet and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There were male and female GPs in the practice which patients could choose to see a male or female doctor. Records provided to us before our inspection showed that 14 of 21 staff from across the practice had received equality and diversity training in 2013. We did not see anything to indicate that staff were not acting in an appropriate way to any patients.

Access to the service

The practice opened from 8.00am to 6.30pm Monday to Friday and appointments were available on these days between 8.00am and 5.30pm. 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. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. The practice had opted out of providing out-of-hours services to its patients and referred them to HDoc's and Care UK out-of-hours service via the 111 service.

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term and multiple conditions. Home visits were made to those patients who needed one. Requests for patients to have home visits were all assessed by the duty GP directly who then decided whether the patient required a visit or not.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and rated the practice well above average in these areas. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 82% were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 76% said they could get through easily to the surgery by phone compared to the CCG average of 69% and national average of 72%.
- 78% described their experience of making an appointment as good compared to the CCG average of 73% and national average of 74%.

The majority of patients we asked were satisfied with the appointments system and said it was easy to use. However, one patient told us they found it a challenge to get a routine appointment the same week but confirmed that they could always get a same day appointment if their need was urgent. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient told us they had needed to make an emergency appointment a few times and was able to get quick appointments.

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 there was a designated responsible person who handled all complaints in the practice.

How to complain information was displayed in the waiting area and available on the practice website and in the practice leaflet. Of the 19 patients we asked, 13 told us they knew how to make a complaint, three weren't sure and three patients said they didn't know.

We reviewed the complaints folder that contained details of nine complaints raised in the last 12 months. All of these complaints appeared to have been dealt with appropriately; investigated and the complaint responded to in a timely manner. All staff reported that complaints which were relevant to them were relayed either at the practice meetings or via individual feedback if this was appropriate.

We looked at two complaints in depth. The first was about customer service and the second about an administration error. Both included communication with the complainant to acknowledge the complaint and apologise. One involved communication by letter and the other face to face with the patient as their complaint was verbal. We saw clear evidence that both complaints had been fully investigated, resolved and learning shared with relevant staff as appropriate.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice vision and values included its aim to deliver a high standard of care to patients whoever they may be and regardless of gender, age, ability, disability, ethnicity, sexuality, religion or language.

Staff all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

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. We looked at six of these policies and procedures. Policies seen included, safeguarding, infection control, whistleblowing, chaperone and equal opportunities. We were told there was no system in place to review policies to ensure they were current and fit for purpose. This was apparent when we looked at the practice whistleblowing policy which stated that it should be reviewed in January 2011. The policy was dated January 2010.

There was a clear leadership structure with named members of staff in lead roles. For example, a health care assistant was the lead for infection control and the senior partner was the lead for safeguarding. Staff were 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 GP and practice management team took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using 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. We were told that QOF data was regularly discussed at clinical meetings but this was informal and records were not kept.

Evidence from various data from sources, including incidents and complaints was used to identify areas where improvements could be made but learning from these was not evident. The practice confirmed they did not maintain an on-going programme of clinical audits. The practice carried out risk assessments for fire safety and legionella and where risks had been identified action plans had been produced and were implemented. Other than these two risk assessments the practice told us it monitored risks on an ad-hoc basis and acted when necessary rather than following a set programme of risk assessments.

There were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice manager and reception manager were responsible for human resource policies and procedures. The practice had a whistleblowing policy which was also available to all staff electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice.

We were told that administration staff meetings took place every three months and minutes the most recent team meeting held in January 2015 were seen. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

We looked at the results of the most recent GP patient survey, published in January 2015 and 87% of patients who responded said they would recommend the practice to someone new to the area. This result was better than average results for the local area and nationally.

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through surveys, friends and family test, comments and complaints received.

The practice had a virtual patient group (VPG) of 13 patients which included representatives from various population groups such as, patients from English, Chinese, and Asian backgrounds. The VPG had representatives ranging from 17 to over 75 years of age. The group was consulted every three months by email to review surveys. The practice

Are services well-led?

Good

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

manager showed us the analysis of the last patient survey, which was considered in conjunction with the VPG. The results and actions agreed from this survey were available on the practice website.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and said they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

During our discussions with the staff across the practice we found there was a clear understanding of the current and future leadership needs of the practice.

Staff told us that the practice was very supportive of training if it was felt it was appropriate. The practice manager told us that guest speakers came to the practice to give talks to staff about specific issues. For example, an in-house talk was provided on domestic violence. Staff also had protected time for training.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not ensured that persons employed for the purposes of carrying on a regulated activity were of good character and that information specified in Schedule 3 was available in relation to each such person employed and such other information as appropriate. Checks missing included Disclosure and Barring Service checks, conduct in previous employment, eligibility to work in the UK and photographic identification. Staff that performed chaperone duties did not have either a criminal records check or documented rationale why such a check was not required. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person must – Operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** We found that the registered provider did not ensure that effective systems were in place to ensure that emergency medicines were available and fit for purpose.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 12 (2)(f&g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person must – Make appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.