Clarence Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Clarence Medical Centre on 10 March 2015. Overall the practice is rated as requires improvement.

We found the practice to be good for providing caring, responsive and well-led services. The practice requires improvement in the safe and effective domains. It also requires improvement for all of the six population groups we assessed.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Communication channels and regular meetings were available to all staff which enabled them to be involved the running of the practice.
- Risks to patients were assessed and well managed. However, infection control guidance was not always followed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Test results may not have been reviewed quickly due to the system used in the practice.
- Staff training was not always identified and monitored to ensure staff could fulfil their roles safely and effectively.
- Patient feedback showed they were treated with compassion, dignity and respect and they were usually involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they sometimes found it difficult to make an appointment with a named GP and that booking an appointment could be hard. The practice had responded to this feedback.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There had a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of practice where the provider must make improvements.

- Ensure the role of infection control lead is clearly defined and that the policy is followed, including regular audit and completing any required actions.
- Change the system for receiving test results to ensure any urgent concerns are dealt with promptly.

Additionally the provider should :

- Identify and deliver the training needs of all staff and develop a system to monitor staff awareness and re-training requirements.
- Review the process of designing care plans to reduce the likelihood of unplanned admissions to hospital to ensure patients are involved in the designing of these plans.
- Update information sources for patients to access guidance on how to book advanced appointments.

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. The infection control policy was not followed and audits were not undertaken since 2013. Infection control training updates were not provided to staff following induction training. 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 patients safe. There were systems to ensure medicines were stored correctly and within their date of expiry. The disaster recovery plan was in the process of being updated and was not available to staff. Safeguarding training was provided and protocols were accessible for staff should they need to refer to safeguarding information.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. The practice did not have a system to ensure staff had received all the training appropriate to their roles and any further training needs would be identified and appropriate training planned to meet these needs. There was risk test results were not always acted on as quickly as they should be. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Plans to reduce the risk of unplanned admissions could be improved to ensure patients were more involved. There was evidence of appraisals for staff. Staff had an awareness of the Mental Capacity Act 2005 but some staff said they would not be confident to implement the Act. Staff worked with multidisciplinary teams in planning and delivering care, such as liaison with district nurses and palliative care teams. The practice reviewed care outcomes and processes where they identified there were potential improvements and we saw evidence that improvements were made as a result.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well in several aspects of care. Patients said they were treated with compassion, dignity and respect and they were usually involved in decisions about their care

Summary of findings

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. Confidentiality was maintained and staff had an awareness of their role in maintaining privacy and preventing private information from being shared.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It was aware of the needs of its local population. Some patients said they found it easy to make an appointment with a GP but some said the appointment system was difficult to use. Survey feedback regarding the appointment system showed patients often found booking appointments difficult as was seeing their own GP. The practice had taken action to improve appointment booking. 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 evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. The practice had considered and was in process of planning for its future in response to the remands of its local population and limitations of its premises. 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 a virtual reference group and was engaged with regularly. Staff had received inductions, regular performance reviews and attended staff meetings and events. However, there was a lack of a plan and programme to identify and deliver training required by all staff.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated requires improvement for the domains of safe and effective. The concerns which led to these ratings apply to everyone using the practice, including this population group. 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. End of life care was well managed and included external professionals in its planning and implementation. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The premises were easily accessible for patients with limited mobility and they were being altered to enable services to be provided on the first floor. Plans for patients at risk of unplanned admissions to hospital were written to reduce the risk of this occurrence. However, they did not indicate that patients were fully involved in creating them.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The provider was rated requires improvement for the domains of safe and effective. The concerns which led to these ratings apply to everyone using the practice, including this population group. Chronic disease management was well managed within the practice, and this was reflected in national data and patient records. The practice achieved the maximum scores in 11 of the long term condition Quality Outcome Framework (QOF) categories in 2013/2014. Plans for patients at risk of unplanned admissions to hospital were written to reduce the risk of this occurrence. However, they did not indicate that patients were fully involved in creating them. 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.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated requires improvement for the domains of safe and effective. The concerns which led to these ratings apply to everyone using the practice,

Summary of findings

including this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, and systems to ensure staff were aware when seeing children who were at risk of harm or abuse. Immunisation rates were close to average for most standard childhood immunisations. The premises were easily accessible for patients attending with prams and buggies. Sexual health advice and services were available to patients.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The provider was rated requires improvement for the domains of safe and effective. The concerns which led to these ratings apply to everyone using the practice, including this population group. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered in response to negative feedback about the appointment system. Extended hours appointments were not available, but were due to be introduced in April l2015. The practice provided a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated requires improvement for the domains of safe and effective. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice had carried out responsive checks for people with a learning disability and offered these patients longer appointment slots. 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. Staff received appropriate levels of training in safeguarding adults and children. Staff confirmed that any patients who did not have an address to provide to the practice, would still be registered and seen by an appropriate clinician.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health, including people with dementia. The provider was rated requires improvement for the domains of safe and effective. The concerns which led to these ratings apply to everyone using the practice, including this population group. Patients 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 told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Counselling was available to patients on-site.

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 31 patients undertaken by the practice and patient participation group (PPG). The practice survey concentrated only on the appointment system. We also considered evidence from the feedback we received on the day from 30 patients and 10 completed CQC comment cards. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed 79% of practice respondents said the GP was good at listening to them and 81% said the GP gave them enough time. Ninety per cent said the last nurse they saw or spoke to was good at listening to them and 88% said the last nurse they saw or spoke to was good at giving them enough time.

Patients said they felt the practice offered a caring and helpful service. Some comments were less positive but these related to the appointments system. Patients noted being treated with respect and dignity on the comment cards. Seventy nine per cent of patients said their GP and 90% said the last nurse they saw treated them with care and concern on the national survey.

The GP national patient survey showed patients had some concerns regarding their involvement in consultations with nurses, as only 76% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care. Seventy two per cent of patients said the last GP they saw or spoke to was good at involving them in decisions about their care. Feedback from patients we spoke with and from comment cards showed no concerns regarding involvement in care and treatment and there were some positive comments related to this.

There was negative feedback regarding the appointment system from patients we spoke with and on comment cards. The national survey found only 46% of patients got to see their preferred GP. Patients we spoke with told us seeing their preferred GP usually required booking 10 to 21 days in advance. Many of the GPs were part time. Eighty three per cent of patients were able to get an appointment to see or speak to someone the last time they tried and 88% said the last appointment they got was convenient. Only 57% described their experience of making an appointment as good compared to 67% in the locality. Patient comments on the last practice survey suggested getting through on the phone and not being able to book in advance was a problem.

Areas for improvement

Action the service MUST take to improve

- Ensure the role of infection control lead is clearly defined and that the policy is followed, including regular audit and completing any required action.
- Change the system for receiving test results to ensure any urgent concerns are dealt with promptly

Action the service SHOULD take to improve

- Identify and deliver the training needs of all staff and develop a system to monitor staff awareness and re-training requirements.
- Review the process of designing care plans to reduce the likelihood of unplanned admissions to hospital to ensure patients are involved in the designing of these plans.
- Update information sources for patients to access guidance on how to book advanced appointments.

Clarence Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector**.** The team included a GP and an Expert by Experience.

Background to Clarence Medical Centre

Clarence Medical Centre is located near the centre of Windsor. The practice premises were purpose build approximately 20 years ago. Patients are registered from the local area.

Approximately 15,000 patients are registered with the practice over two sites, with Clarence Medical Centre being the local practice to 10,000 of those patients. The practice population has increased by 1800 patients in the last four years. The registered population has a very high contingent of patients aged 20-24 but this is a reflection of the branch site which is based within a university college. The number of older patients and young children were below the national average. The practice performs well against nationally recognised quality standards. The Quality and Outcomes Framework data available to CQC shows over 98% of targets are met. A wide range of primary medical services are provided including clinics for patients with long term conditions and for child health.

Care and treatment is delivered by six GPs, three nurses, two health care assistants, and a practice manager and administration staff. The GPs and nurses are supported by a practice manager, patient services manager and a team of administration and reception staff.

The practice is a member of Ascot, Windsor and Maidenhead CCG.

The Clarence Medical Centre,

Vansittart Road

Windsor

SL4 5AS

The practice has another CQC registered location which is classed as a branch site by the practice:

Royal Holloway Health Centre

Egham Hill

Surrey

TW20 0EX

This was a training practice. The practice had a General Medical Services (GMS) contract. GMS contracts are directly negotiated between the General Medical Council and the practice.

We visited the Clarence Medical Centre but did not visit Royal Holloway Health Centre as part of this inspection.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider and NHS 111.

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 is meeting the legal

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

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

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), local Healthwatch, NHS England and Public Health England. We visited Clarence Medical Centre on 10 March 2015. During the inspection we spoke with GPs, nurses, the practice manager and reception staff. We obtained patient feedback from speaking with patients, comment cards, the practice's surveys and the GP national survey. 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 people's needs?
- Is it well-led?

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients were communicated and investigated. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The manager told us they received concerns from members of staff and these would be raised at appropriate meetings. We saw evidence that there were numerous meetings where incidents could be and were regularly discussed. We reviewed safety records, incident reports and minutes of meetings where these were discussed in team meetings. This showed the practice had managed these consistently.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred in the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda. Staff told us significant events were investigated, discussed at relevant staff meetings and all learning outcomes disseminated to staff. The practice reviewed the learning outcomes after any changes to protocol or practice had been made in order to ensure that learning was embedded. For example, late diagnosis of a cancer was identified following a patient's referral to a hospital. The investigation outcome was shared with the relevant hospital to help them identify what caused the late diagnosis. There was also a significant event related to the practice and protocols within the nursing team which led to a change in their protocol and responsibilities within the team.

Where complaints identified that something had gone wrong, the practice investigated the concern, informed staff of any learning, reviewed protocol and policies and issued an apology where this was appropriate.

National patient safety alerts were disseminated among staff through email, meetings and staff briefings. The practice had a varied means of communication among staff.

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. GPs had undertaken level three child 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 to all staff.

The practice had appointed a dedicated GP as a lead in safeguarding vulnerable adults and children. All staff we spoke with were aware of who the lead was 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. We saw examples of how the system flagged patients who may be at risk of abuse.

There was a chaperone policy which was visible in consulting rooms and in the entrance area of the practice. Nurses undertook chaperone duties and there was a plan for them to be trained as chaperones in Spring 2015. Receptionists did not undertake chaperone duties at the time of the inspection but there was a plan to train them in the role at the same time as nursing staff.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a schedule for checking that medicines were kept at the required temperatures. Staff knew what action to take in in the event that a fridge should stop working, such as a power cut. We saw records of temperature checks were regularly undertaken and that the temperatures were

within the required range to ensure medicines were stored appropriately. Staff who took receipt of and who administered vaccines told us they received training to do so.

Processes were in place to check medicines stored in treatment rooms were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. The lead nurse was aware that some of the patient group directives (these enable nurses to administer certain medicines with the authority of a prescriber) needed updating and they informed us where this was the case, prescriptions were used to ensure medicines were administered within guidelines. A health care assistant (HCA) was able to locate and show us their patient specific directives used when they administered vaccines.

There was a system in place for the management of patients taking high risk medicines, which included regular monitoring in line with national guidance

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

At the time of the inspection there was building work underway at the practice. We observed the premises to be clean and tidy, specifically treatment and consultation rooms. The practice used contract cleaners who had a schedule of cleaning. The practice staff undertook checks on the cleanliness of the premises but there was no formal check of cleaning, such as periodic checks of high and low surfaces. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. They were not certain when they had last undertaken infection control training. There was no record to suggest when had last undertaken this training. All staff received induction training about infection control specific to their role but there was no system to ensure staff received regular updates. Staff were not aware of any infection control audits being undertaken. However, we looked at the infection control policies and found an audit from March 2013. This identified an action plan to be undertaken to ensure that infection control guidance was followed. However, the action plan was not completed as we saw some concerns identified in the audit which had not been acted on. For example, an update on all staff Hepatitis B immunisations was required and there was an action to add this to a spreadsheet, but when we asked for evidence the practice could not show us the log. Infection control training updates were identified as a need for staff who had missed them in 2013 but the practice could not provide evidence this had been provided. Some changes had been implemented as a result of the audit, such as changing to hands free taps. The practice was not using the audit tool to effectively monitor infection control in the practice.

The infection control policy contained supporting documentation and was available for staff to refer to. This included a sharps injury protocol which was displayed in clinical treatment rooms. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Equipment was cleaned regularly and staff knew who was responsible for ensuring equipment was clean and hygienic.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Sharps boxes were available in treatment and consultation rooms and were only filled up to the maximum mark. Filled boxes were removed. However, clinical waste, including sharps boxes, was not stored securely and was accessible to the public.

The practice did not have policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However, the practice did not have cold water tanks and had received advice that they would therefore not need a full risk assessment.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A

schedule of testing was in place. We saw evidence of calibration of relevant equipment. For example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer were all calibrated annually.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Nursing staff who had been employed prior to the requirement for DBS checks had been subject to Criminal Record Bureau (CRB) checks. The practice had a recruitment policy that set out the standards it followed when recruiting staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was minimal use of external covering staff, such as locum GPs, which showed that cover arrangements worked well in the practice. The number of part-time GPs made it difficult for patients to see their preferred GP and this was reflected in the 2014 national GP survey. The practice was trying to recruit GPs to improve access to named and preferred GPs but partners told us this had proved difficult. 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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had health and safety literature available to its staff. We noted that health and safety training was not provided to staff.

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.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. They included medicines for the treatment of a variety of medical emergencies. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice manager told us a business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. They informed us this document was under review. The practice had carried out a fire risk assessment that included actions required to maintain fire safety. There was a designated fire warden but they had not received specific training to reflect their role.

Requires improvement

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 evidence that new guidelines were disseminated and that the practice's performance was reviewed where necessary. 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.

The GPs told us they trialled leading in specialist clinical areas such as diabetes and respiratory diseases, but this system did not suit the practice and so the practice did not continue with the system. Practice nurses led in specific areas of healthcare. This enabled the practice to effectively manage specific long term conditions such as diabetes. 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 continually review and discuss new best practice guidelines for the management of specific medical conditions. We saw clinical meeting minutes which confirmed that this happened.

We completed a review of case notes for patients with various long term conditions which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice was above the regional average for referrals in previous years and had undertaken a review of its referrals and audits to improve. The action had reduced the referral rates to below the regional average. GPs told us that all referrals were reviewed by a local hub before being passed onto secondary care services.

The practice undertook the enhanced service for unplanned admissions to hospital. This identified approximately 250 patients at risk of going into hospital and involved planning to reduce the risk of patients being admitted. However, we found the plans did not always include recording of patients' involvement or wishes. This could have limited the effectiveness and quality of the plans if patients' personal preferences and wishes were not made clear. The practice informed us that the plans were sent to patients who could review and make amendments before being finalised.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses 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

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 practice showed us several clinical audits which had been undertaken in recent years. Audits were undertaken in response to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). We saw some completed audits such as reviews of the use of medicines and specific treatments in the care of certain conditions were based on best practice guidelines. We saw there were plans for the audits to be repeated but these had not yet taken place. There were examples of completed audits, such as a hospital discharge audit which had been repeated to determine whether improvements to practice which had been identified were acted on. We saw there was marginal improvement in the completed (repeated) audit. Outcomes from audits were shared with staff at clinical team meetings and the outcomes were accessible to staff on a shared computer drive.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed well on QOF across the majority of clinical outcomes for patients achieving 98% overall in 2014. Exception reporting was low (exceptions may be

Requires improvement

Are services effective?

(for example, treatment is effective)

made when patients are not able to be seen or not able to receive treatment in line with national standards). The practice achieved the maximum QOF scores in a number of long term condition QOF categories in 2013/2014.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They 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.

The practice had implemented the gold standards framework for end of life care. It 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 and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs. All the GPs attended local meetings to discuss clinical topics with other GPs and share learning. All 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).

The practice had induction plans for different staff roles which included various aspects of training specific to the practice's policies and protocols. All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was responsive when staff identified training needs they were supported and funded for relevant courses. Nurses attended courses for the care of respiratory diseases, diabetic care and for initiating insulin for diabetics. One staff member had been trained in monitoring patients who take medication to prevent blood clots, which requires regular checks due to the associated risks.

There was no system for identifying non-clinical training which may be required by all staff such as information governance, equality and diversity or health and safety training. Some courses were identified as necessary for non-clinical staff such as safeguarding and there was a plan to deliver this training to non-clinical staff within the practice such as receptionists. Staff were provided with some training as part of their inductions such as relevant infection control training. However, there was no system or programme to deliver training periodically to ensure staff awareness was maintained.

There were systems in place to disseminate some relevant learning through a structure of team meetings, such as changes to protocols or policies. We saw minutes of the various team meetings. All staff groups took part in the quarterly review of significant events. We saw that the minutes of the meeting, including the learning points were circulated to all staff. The nursing team were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines.

Working with colleagues and other services

The practice worked with other service providers to provide patients' care including those with complex care needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice worked with the district nursing team, health visitors and midwifes. GPs told us there was a multi-disciplinary team meeting every month. This included the district nurses, health visitors and palliative care nurses. The minutes of the meetings showed us that care of patients that required the input from various staff was discussed to ensure co-ordinated care was given. For example, the support required by patients in receipt of palliative care was discussed and co-ordinated. There was evidence of working with other healthcare professionals and voluntary bodies.

Information sharing

The practice used electronic systems to communicate with other providers and internally. 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

Requires improvement

Are services effective?

(for example, treatment is effective)

referrals and the practice used the Choose and Book system (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).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to 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. Test results sent from laboratories were sent straight to the GP that ordered the test. Due to the number of part time GPs there was a risk that a test result may not been seen by a GP which required attention the same or next day after receipt. The practice informed us that GPs were alerted by the laboratory if results required urgent attention. This relied on the laboratory always communicating effectively with the practice and test results may still not be dealt with if this communication did not take place.

Consent to care and treatment

We found that GPs and nurses were aware of the Mental Capacity Act 2005. All the staff we spoke with understood the key parts of the legislation. Nurses gave examples of when they would need to refer the principle of the Act. Nursing staff we spoke with told us they would not feel confident in making best interest decisions. This could inhibit a nurse's ability to administer a vaccine to a patient with dementia, for example.

Staff were aware of the Gillick Competencies (this refers to the rights of children to make decisions about their treatment between the ages of 13-16). Staff told us they were aware of their responsibility to gain consent from patients and we saw evidence in patient records that consent was discussed.

Health promotion and prevention

GPs told us of a range of health promotion services they were able to access for their patients. For example, counselling was available in the practice. Weight loss advice and support was provided to over-weight patients. This included referrals to gyms and dieticians. The practice hosted annual eye screening checks for diabetics. Patients with alcohol misuse problems were referred to local support services. Health information was made available during consultation and GPs used literature available from online services to support the advice they gave patients. The website contained health information for children, pregnant women, men, women, older patients and information on sexual health. A range of health promotion information was available in both the main waiting area and in clinical rooms. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years, but only a very few patients had used the service. The uptake of this service was low in the locality.

The practice kept a register of all patients with a learning disability but they were not offered an annual health check. Staff told us the six learning disabled patients registered were provided with health checks when they required them. The practice had also identified the smoking status of 90% of patients over the age of 16 (above the national average) and actively offered nurse-led smoking cessation clinics to 91% of these patients. Staff told us patients were offered referrals to the smoking cessation service during consultations.

The practice's performance for cervical smear uptake was 81% in recent years, which matched the national average and target of 80%. 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 for child immunisations close to the average for the CCG. Children under 12 months had an uptake of 93% and 90% under 24 months. Flu vaccinations were offered and the uptake among those over 65 was the same as the national average (74%) and for those considered at risk due to medical conditions was above national average (58%). Mental health services were used by the practice to encourage those suffering with mental health to receive addition support. Sexual health and contraception services were available on site. A nurse had been trained in providing contraception services.

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 and a survey of 31 patients undertaken by the practice and patient participation group (PPG). The practice survey concentrated only on the appointment system. We also considered evidence from the feedback we received on the day from 30 patients and 10 completed CQC comment cards. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed 79% of practice respondents said the GP was good at listening to them and 81% said the GP gave them enough time. Ninety per cent said the last nurse they saw or spoke to was good at listening to them and 88% said the last nurse they saw or spoke to was good at giving them enough time.

Patients said they felt the practice offered a caring and helpful service. Some comments were less positive but these related to the appointments system. Patients noted being treated with respect and dignity on the comment cards. Seventy nine per cent of patients said the last GP they saw treated them with care and concern and 90% said the last nurse they saw treated them with care and concern on the national survey.

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 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. Patient feedback had led to the practice to make changes to the layout of the premises in order to improve confidentiality at the reception desk. The reception area was being moved to an area away from the waiting area. There was a glass screen being put in to ensure patients could not overhear potentially private phone conversations.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us patients were offered a private room if they did not want to speak with staff in the public areas of the practice.

Care planning and involvement in decisions about care and treatment

The GP national patient survey showed patients had some concerns regarding their involvement in consultations with nurses, as only 76% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care. Seventy two per cent of patients said the last GP they saw or spoke to was good at involving them in decisions about their care. Feedback from patients we spoke with and from comment cards showed no concerns regarding involvement in care and treatment and there were some positive comments related to this. We found that care planning as part of an enhanced service did not include patients fully in the creation of the plans. For example, there was no reference to advanced treatment decisions or do not attempt resuscitation in the event of cardiac arrest. This may have led to patients' preferences not being respected in the delivery of care and treatment.

Staff told us that translators were available to be booked for patients who did not have English as a first language to enable them to discuss and be involved in their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room informed patients of how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Support services for patients with mental health conditions were promoted by the practice. We saw evidence that the practice promoted bereavement support to the families of patients who were receiving end of life care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and 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. The practice had a young population, but this was largely due to the other practice location registered separately with CQC, which served a student population. Clarence Medical Centre served Windsor patients with a broader mix of ages and backgrounds than the branch practice.

Height adjustable benches, which made it easier for patients who had limited mobility, were available in some consultation rooms. In response to feedback about the difficulty in getting through to the surgery by phone, the practice had added phone lines at reception. There was no online booking facility at the time of the inspection but the practice was implementing this in the coming months, due to patient feedback from the 2014 practice survey. Phone appointments had also been introduced as a result of patient feedback regarding access to appointments. Staff told us this enabled all patients contacting the practice to have access to GP if they requested this.

Patients could be referred to an onsite dermatology service. Patients who required travel immunisations or health advice could call the practice and a plan is put in place before a patient attends the practice as to what immunisations or medicines were required.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services, but did not use a phone translation service. This could have made it difficult for patients with urgent concerns who did not speak English to access care and treatment at the practice. Staff told us that there were very few non-English speaking patients. Staff confirmed that any patients who did not have an address to provide to the practice, would still be registered and seen by an appropriate clinician.

The premises and services had been adapted to meet the needs of patient with disabilities or limited mobility. Level access at the front of the building made it suitable for wheelchairs and mobility scooters. The practice had a schedule of work underway which included changing the heavy doors to automatic ones. This also included installing a lift so patients with limited mobility could be seen on the first floor. The premises had wide corridors and doorways were wide enough for large wheelchairs.

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

Appointments were available from 8.30am to 6.00pm on weekdays. There were no extended hours at the time of the inspection but the practice had planned to implement extended hours in April 2015. Patients could book appointments in person or on the phone. GPs and the practice manager told us if patients called before 8.30am they were guaranteed an appointment if they needed one. They also told us more appointments were released at 2pm for patients who called in the afternoon requiring same day appointments. Receptionists asked patients why they needed an appointment if one was requested so they could ensure the patient saw or spoke to the right person.

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits. There was no facility to book appointments online. There was no guidance about how to book appointments in advance. 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.

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 patients who required them, by a named GP and to those patients who needed one.

There was negative feedback regarding the appointment system from patients we spoke with and on comment cards. The national survey found only 46% of patients got to see their preferred GP. Patients we spoke with told us seeing their preferred GP usually required booking 10 to 21 days in advance. Many of the GPs were part time. Eighty three per cent of patients were able to get an appointment

Good

Are services responsive to people's needs?

(for example, to feedback?)

to see or speak to someone the last time they tried and 88% said the last appointment they got was convenient. Only 57% described their experience of making an appointment as good compared to 67% in the locality. Patient comments on the last practice survey suggested getting through on the phone and not being able to book in advance was a problem. The introduction of more phone lines and online booking showed the practice was responding to these concerns. However, there could be clearer information for patients regarding how they could book advanced appointments.

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 in line with recognised guidance and contractual obligations for GPs in England. We looked at several complaints and found they were investigated robustly and responded to. The practice reviewed complaints regularly to detect themes or trends at staff meetings. We saw that information was available to help patients understand the complaints in the form of information in the practice and on the website.

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 had a clear vision to deliver high quality care and promote good outcomes for patients. It was creating extra consultation rooms to reflect the increased demand in its patient population and was considering an extension to the practice. The practice was aware that capacity was one of the potential causes of the concerns patients had about accessing appointments. The practice was currently trying to recruit another GP to increase its appointment capacity. All the staff we spoke with reflected the practice values and knew what their responsibilities were in relation to delivering the values.

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 policies and found most were reviewed regularly and up to date.

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. Most staff were clear about their own roles and responsibilities. However, the lead role in infection control had been passed onto a new member of staff in 2013 but the role was not taken on properly and responsibilities were not clearly defined. 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. We saw that QOF data was discussed at staff meetings. Where action was required to improve standards the practice reviewed protocols and took action. For example, the referrals rates in the practice were significantly reduced as a result of review, audit and changes to practice.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. There was no overall programme of clinical audit, rather audits were in response to areas of concern or individual GP or trainee GP interests. The audits were disseminated to staff and where improvements were identified they were implemented.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. These included risk assessments on the premises and common risks, such as fire safety.

Leadership, openness and transparency

We saw minutes from weekly partnership meetings and monthly clinical and multi-disciplinary meetings. Daily meetings were held for staff to discuss concerns or complex patient care issues. 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 to their line manager. Staff we spoke with knew who to report concerns to about specific issues such as safeguarding and also had line managers to ensure they knew where they could access support if needed.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and used external feedback from the national GP survey. We looked at the results of the annual patient survey and saw there was some negative feedback about the telephone system and accessing appointments. The practice had responded to this feedback by changing the telephone system and was due to implement online appointment booking. The practice had a virtual patient participation group (PPG) which communicated via e-mail and had over 20 patients involved. The practice manager told us the PPG was an effective means of engaging and represented the local population.

The practice had gathered feedback from staff through meetings and appraisals. 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.

Management lead through learning and improvement

Are services well-led?

Good

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

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. Staff told us that the practice was very supportive of training and that they could attend external training events. However, there was no overall training programme or system to identify which staff had completed training required for their roles. There was no training plan to compliment the care and treatment provided to patients which would benefit them and the practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, there was a significant event related to the practice and protocols within the nursing team which led to a change in their protocol and responsibilities within the team.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was not assessing the risk of, preventing, detecting and controlling the spread of health care associated infections. Regulation 12(1)(2)(h)**