

Drs Weaver, Shand & Assadourian

Quality Report

Odiham Health Centre

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Odiham

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Weaver, Shand & Assadourian also known as Odiham Health Centre on 24 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the all the population groups it provided services for. It required improvement for providing safe services.

Our key findings were as follows:

- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

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

Importantly, the provider must:

- Carry out a legionella risk assessment.
- Complete an annual infection control statement.
- Ensure medicines are kept securely and only accessible to authorised people.
- Ensure cleaning fluids are stored securely and only accessible to authorised people.

Summary of findings

- Carry out a Disclosure and Barring Service check or document the rationale why such a check is not required for staff who perform chaperone roles.

In addition the provider should:

- Review fire emergency plans for the use of the first floor by patients with mobility impairments.

- Maintain a record of induction training for newly appointed staff.
- Ensure all relevant staff receives infection control training

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?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Risks to patients who used services were not always assessed which meant systems and processes to address these risks were not implemented to ensure patients were kept safe.

Medicines and vaccines that were kept in the medicines fridges were not stored securely. Infection prevention and control systems were in place and regular checks were carried out to ensure that all areas were clean and hygienic however only one member of clinical staff had received staff training on infection control since 2012 and an annual infection control statement had not been produced.

Areas of concern also included management of medicines, effective cleaning fluid storage, emergency evacuation plans and legionella safety.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from the 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. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice had conducted appraisals and had personal development plans for staff.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Patients said they were able to make an appointment with their named GP and that there was continuity of care, with urgent appointments available the same day.

Good



Summary of findings

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. The practice learnt from complaints and shared learning with relevant staff.

Are services well-led?

The practice is rated as good for being well-led. There was a clear vision and strategy in place that was shared with the staff. Staff also knew their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings and systems were also in place to monitor and improve quality and identify risk. The practice responded to feedback from staff and patients.

Good



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

The practice undertook audits and increased detection of patients who have dementia in order to offer more care to the patient and carer. Home visits were carried out for those patients too frail to attend the surgery. Patients were given adequate time whenever they interacted with the practice and especially during their appointments. Patients with specific difficulties were offered longer appointments. GPs, practice nurses and community nurses visited patients at home for their routine chronic disease management and monitoring. The practice premises were designed to facilitate easy access for patients who were frail or who had disabilities.

Good



People with long term conditions

The practice identified those patients with long term conditions who were at high risk of hospital admission. Patients were identified using a combination of risk tools, chronic disease lists and personal knowledge. A list of 2% of patients over the age of 18 at high risk of admission with chronic disease was maintained. Each patient had a personalised care plan which was reviewed at least three monthly by their named GP. Those patients on the 2% list were also reviewed monthly by the GP's and the community nursing team. The practice was pro-active to meet targets for patients with chronic diseases.

Good



Families, children and young people

The practice had families and children of the serving personnel at RAF Odiham registered as patients. The transient nature of this population was recognised by the practice. Safeguarding concerns were actioned appropriately. A named safeguarding lead coordinated these and received regular multi-agency safeguarding reports and made relevant staff aware of any concerns raised about any of their registered children or families. This enabled the practice to support the family or young person where needed. Midwives attached to the practice provided clinics. Nursing staff changed child immunisation clinic into an appointment system which fitted in better with patients' needs and resulted in a 98% uptake in child immunisations.

Good



Working age people (including those recently retired and students)

The practice offered a range of appointments including early mornings at 7.30am, a late evening until 8pm and Saturday mornings. It engaged with the NHS programme of health checks for the over 40's to support the patients with early interventions to

Good



Summary of findings

reduce the long term risk of chronic disease and provided general health education. Access to GP advice was provided through telephone consultations and on-line services were available to book appointments or order repeat prescriptions. Patients with urgent health needs were never turned away; all were given the opportunity to speak to a GP on the same day and if they needed to be seen would be given an appointment at the end of the GP's list.

People whose circumstances may make them vulnerable

The practice had policies for both adult and child safeguarding. Staff were trained to recognise features that may suggest a vulnerable person was in need of safeguarding support. The practice ensured that 'looked after children' were coded as such, so that all staff were aware that the young person was vulnerable. Two GPs provided general practice services for students at a specialist school for disabled children which ensured continuity of care when they were away from home. Longer appointments were routinely given to vulnerable patients.

Good



People experiencing poor mental health (including people with dementia)

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had in place advance care planning for patients with dementia. The practice had access to a variety of mental health services both within the practice and elsewhere. Services included a consultant psychiatrist, counsellor specialising in the young, iTalk referral or self-referral, Relate at Odiham Cottage Hospital, various therapists for young patients, Basingstoke counselling service and the Alzheimer's association.

Good



Summary of findings

What people who use the service say

We received 12 completed patient comment cards and spoke with nine patients at the time of our inspection visit. These included older people, mothers with babies, vulnerable people and people of working age.

Patients we spoke with and who completed Care Quality Commission (CQC) comment cards were almost all 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 GP was of a very high standard.

The practice had a very active patient reference group who improved communication between the practice and its patients. 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. 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;

- 81% of respondents found it easy to get through to the surgery by phone
- 93% of respondents said the last appointment they got was convenient
- 92% of respondents said the last GP they saw or spoke to was good at listening to them
- 97% of respondents said they had confidence and trust in the GP treating them

Areas for improvement

Action the service **MUST** take to improve

- Carry out a legionella risk assessment.
- Complete an annual infection control statement.
- Ensure medicines and prescriptions are kept securely and only accessible to authorised people.
- Ensure cleaning fluids are stored securely and only accessible to authorised people.
- Carry out a Disclosure and Barring Service check or document the rationale why such a check is not required for staff who perform chaperone roles.

Action the service **SHOULD** take to improve

- Review fire emergency plans for the use of the first floor by patients with mobility impairments.
- Maintain a record of induction training for newly appointed staff.
- Ensure all relevant staff receives infection control training

Drs Weaver, Shand & Assadourian

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 Drs Weaver, Shand & Assadourian

Drs Weaver, Shand & Assadourian, also known as Odiham Health Centre, is a purpose built surgery situated in the centre of Odiham, Hampshire.

Drs Weaver, Shand & Assadourian has an NHS general medical services (GMS) contract to provide health services to approximately 11,000 patients. Surgeries are held daily between the hours of 9:00am - 12:00 noon and 2:30pm - 6:00pm, Monday to Friday. Nurse clinics are held daily between the hours of 8:00am and 5:30pm. Early morning GP surgeries are held on Tuesdays and Fridays and evening surgeries on Wednesdays. Saturday morning GP and nurse surgeries are held on alternate weekends. The practice has opted out of providing out-of-hours services to their own patients and refers them to Hantsdoc via the 111 service.

The mix of patient's gender (male/female) is almost half and half. The practice has a higher number of patients aged between 45 and 49 years old when compared to the England average. The practice is based in an area of low deprivation and has a high number of patients who are families of serving members of RAF Odiham.

The practice has three GP partners, four salaried GPs and one GP registrar who together work an equivalent of 7.2 full time staff. In total there are three male and five female GPs. The practice also has five practice nurses and two health care assistants. GPs and nursing staff are supported by a team of 19 administration staff. The practice administration team consists of receptionists, secretaries, quality control assistant, summariser, finance assistant and the practice manager. Odiham health centre is also a training practice for GPs, medical students and registrars.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

We carried out our inspection at the practice situated at;

Odiham Health Centre

Deer Park View

Odiham

Hampshire

RG29 1JY

Detailed findings

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.

How we carried out this inspection

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

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice

policies, procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website and NHS National GP Patient Survey.

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 and the practice's patient participation group. We reviewed comment cards and feedback where patients and members of the public shared their views and experiences of the practice before and during our visit.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints it received from patients. The practice had a system for managing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency. Alerts were received electronically by a GP who was the safety alert lead. Alerts were emailed to all clinical staff for their information. All GPs had a buddy to ensure all documents and patient's results were seen and acted upon when they were away for a day or on holiday.

Staff were also aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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 systems in place to monitor patient safety. Minutes of meetings demonstrated that significant events and changes to practice were discussed with all practice staff including the nurses and administration staff as appropriate. Action was taken to reduce the risk of recurrence in the future. The GP completed evaluations and discussed changes their practice could make to enable better outcomes for their patients. A partner GP was the significant event lead. They oversaw all events to ensure they were investigated and shared with relevant staff.

Significant events that we reviewed showed the date the event was discussed; a description of the event, what had gone well, what could have been done differently, a full reflection of the event and what changes had been carried out. For example, a patient became unwell whilst having a contraceptive device fitted. There was only a GP present with them which made alerting staff to assist difficult. As a result the practice changed its protocol to ensure a nurse would always be present in future when these devices were fitted.

Reliable safety systems and processes including safeguarding

The practice had detailed child protection and vulnerable adult's policies and procedures in place, which incorporated information about the Mental Capacity Act 2005. Information supplied showed that all the GPs and trainees had received level three safeguarding children training.

The practice had a GP who was the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary knowledge and experience to enable them to fulfil this role. We saw comprehensive information about child and adult protection, mental capacity and lasting power of attorney for staff to refer to. This information included contact details of external agencies such as the local authority safeguarding team and police. Staff told us how they would respond if they believed a patient was at risk. This involved referring to the safeguarding information folder held in reception and seeking guidance from the safeguarding lead.

Where safeguarding concerns already existed about a family, child or vulnerable adult, alerts were placed on a patient record to ensure information was shared between staff to ensure continuity of care. We were shown several sets of anonymised patient records which confirmed an alert was present. Regular weekly meetings took place between the safeguarding lead, health visitor and school nurse to review vulnerable children.

A chaperone policy was in place. Notices alerting patients to the availability of a chaperone were available in the waiting area, the practice website and the practice leaflet.

Medicines management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations. The practice had in place standard operating procedures for controlled drugs in line with good practice issued by the national prescribing centre. Medicines administered by the nurses at the practice were given under a patient group direction which is a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines.

Are services safe?

Controlled drugs were held securely and only accessible by a coded lock known only by two nominated clinical staff. We were told that controlled drugs were no longer required at the practice and the disposal of these was being arranged for collection.

A prescription policy was viewed on the practice's internal computer system. Blank prescription serial numbers were logged when delivered to the practice and stored securely. Clinicians had to request them from administration staff, but they were not accounted for when they were handed out.

A nominated member of staff was responsible for monitoring stocks of medicines and vaccines to ensure they were in date and available. We saw that emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these to be in date, stored safely and where required, were refrigerated.

Medicine fridge temperatures were checked and recorded daily to ensure the medicines were being kept at the correct temperature. Reception staff knew what to do when a delivery of refrigerated items was accepted and explained the process to us. Staff also demonstrated an understanding of the process they would follow should a fridge breakdown which included moving stock to a second fridge and contacting the company who supplied the medicines for advice. Whilst medicines were monitored appropriately, two of the four fridges used were not locked which meant that these were accessible to unauthorised people. We spoke to the practice manager about this who told us they would rectify the situation as a matter of urgency.

Cleanliness and infection control

We found the practice to be clean at the time of our inspection. A system was in place for managing infection prevention and control however an annual statement had not been produced. This statement should follow the guidance as detailed in the Health and Social Care Act 2008 - Code of Practice on the Prevention and Control of Infections.

A nurse was responsible for infection control. Records showed this nurse had received infection control training in

2015. Records also showed that only two other clinical staff had received annual infection control training in 2012. The remaining clinical staff had 'policy aware' highlighted on the training matrix we were given before our visit.

We saw that an audit relating to infection control had been completed by a lead nurse in December 2014 and areas for improvement included the cleaning of curtains in consulting rooms. This had been actioned and a programme developed to clean the curtains again in six months. Another area identified that blood pressure monitoring cuffs were not clean. We saw a protocol in place for staff to follow to prevent a reoccurrence of this issue.

Systems were in place for ensuring the practice was regularly cleaned. A check list was in place for cleaning staff to indicate when cleaning was completed. The infection control lead told us that visual checks of cleaning standards were made but records not kept. Cleaning materials for the cleaner to use were stored in unlocked filing cabinets in a stairwell that was accessible to unauthorised people which appeared to not follow Control of Substances Hazardous to Health (COSHH) Regulations 2002. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way.

Staff were provided with personal protective equipment which included disposable gloves and aprons infections whilst examining or providing treatment to patients. These items were seen to be readily accessible to staff in the relevant consulting/treatment rooms. We talked to reception staff about handling samples provided by patients, they had a sound knowledge of how to deal with these and a written protocol was in place.

We looked at the treatment rooms used for carrying out minor surgical procedures. We found these rooms to be clean and fit for purpose and appropriate signs were displayed to promote effective hand washing techniques. Sharps boxes were provided for use and were positioned out of the reach of small children. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal. The practice kept waste collection notes on file in accordance with the clinical waste regulations. The practice did not have a policy for the management, testing and investigation of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A Legionella risk assessment had not been carried out.

Are services safe?

Staffing and recruitment

The practice had sufficient staff to provide care and treatment to patients. The staff team were well established and most had worked at the practice for many years. Non-clinical staff were also multi skilled which enabled them to cover each other in the event of planned and unplanned absence. For example, the receptionist could carry out administrative tasks.

A formal recruitment process was in place. This included obtaining information to demonstrate appropriate checks had been made to ensure new staff were appropriately qualified, had medical indemnity cover and were currently registered with a professional body. For example, the general medical council registration for GPs and nursing and midwifery council registration for nurses. We were told that all staff signed a confidentiality agreement at induction stage.

However, we looked at three sets of records for staff, who had started to work at the practice from April 2013, and found none of these had evidence to confirm that they had completed a full induction programme.

A Disclosure and Barring Service (DBS) check had been conducted on all clinical staff to assess their suitability to work with potentially vulnerable patients.

We were told that the practice had three trained chaperones who had all received a DBS check. Other staff we spoke with told us that they also performed chaperone duties but records showed that they had not received any formal training for this role or had a DBS check carried out. We asked about this and was told that at no time would a chaperone be left alone with a patient. This arrangement was confirmed by staff who were chaperones but this was not formally recorded in any risk assessment. We spoke with the practice manager about the need for this to be carried out or a documented rationale why such checks were not required especially for those staff who acted as chaperones.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatment. Equipment checks were regularly carried out in line with the manufacturer's recommendations. Equipment included fire extinguishers which were maintained and tested yearly.

Records confirmed that clinical equipment which included blood pressure monitors, weighing scales and electrocardiogram machine were calibrated in February 2015. Portable electrical equipment had also been tested in February 2015.

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 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 noted that some areas of safety were being monitored and discussed routinely but areas such as infection control and safeguarding training were not.

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

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. The practice had an electronic emergency call system in place on every computer and telephone to enable staff to call for help if they needed urgent assistance. This could be for safety or medical reasons.

Emergency equipment was available including access to oxygen and an automated external defibrillator. A defibrillator is used to attempt to restart a person's heart in an emergency. Staff were able to clearly describe to us how they would respond in an emergency situation. We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone for example, if they were experiencing chest pains, this included calling 999 for patients where required.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Staff knew the location of this equipment and records confirmed that it was checked regularly. We

Are services safe?

saw evidence that all clinical staff received basic life support (BLS) training in the last 12 months. Nine administration staff also received BLS training in February 2015

The practice had a disaster recovery plan that included arrangements about how patients would continue to be supported during periods of unexpected and/or prolonged disruption to services. For example, a power cut loss of water supply or staff sickness. There was a mutual

arrangement with a second practice which ensured patient care was maintained in the event of an emergency. Staff told us they would move services to this practice if Odiham Health Centre was out of action.

Fire safety checks and full fire drills had been carried out. We were told the first floor was routinely used by patients. We asked staff how they would evacuate a patient down the stairs in event of an emergency which may render the lift unusable. We were told they had not thought about this and would review arrangements for patients using the first floor that had mobility impairments.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice was structured, organised and operated systems to ensure best practice was followed. Clinical practice was evidence based and underpinned by nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE), local guidelines, guidance published by professional and expert bodies, and within national health strategies which were used to inform best practice. We were provided with examples of where the practice had made changes to the care and treatment of patients in line with updated guidance from NICE. For example, management of patients with long term conditions such as chronic kidney disease.

Care plans were in place for patients who were identified as needing them, these included patients over 75 and those with specific conditions such as asthma, atrial fibrillation and heart failure. The GPs told us they led in specialist clinical areas such as respiratory medicine, diabetes and cardiology.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary care review

meetings were held with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet patient's physical and emotional needs.

GPs at the practice had different areas of responsibility. For example, one GP attended the monthly Clinical Commissioning Group (CCG) meetings and fed back information to their colleagues, whilst another GP attended prescribing meetings and did the same.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. If information was deemed to be particularly

significant, it was flagged to appear on the patient's home screen so it was immediately visible to the GP or nurse treating them. This included information such as whether a person was a carer

or a vulnerable person.

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. GPs confirmed that they followed evidence based practice protocols. They also confirmed that they made use of NICE guidelines and guidance received from local commissioners. The practice undertook a small amount of minor surgical procedures for example, mole removal. Staff carried these out in line with their registration and NICE guidance. Staff were appropriately trained and kept up to date to ensure they were proficient in carrying out procedures. For example, records confirmed that nurses received additional training in areas such as diabetes and asthma.

The practice routinely collected information about patient's care and outcomes and used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. QOF data show that patients with long term conditions were being monitored and successfully treated.

We looked at a total of 12 clinical audits and saw that changes had been Implemented and improvements had been made. Examples included appropriate prescribing for patients with osteoporosis and patients who had atrial fibrillation.

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, 97% of respondents had confidence and trust in the GP they saw or spoke with.

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

A good skill mix was noted amongst the GPs, nurses and health care assistants. Patients had an option of seeing male or female GPs. All GPs were up to date with their

Are services effective?

(for example, treatment is effective)

yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

There were arrangements in place to support professional development. These included annual staff appraisals. Staff confirmed there were annual appraisal meetings which included a review of their performance, forward planning and the identification of training needs. We were told these were very positive and training requests were always accommodated. For example one nurse told us about receiving training in diabetes care management to enable them to perform this role.

Working with colleagues and other services

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 midwives, 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 closely with the palliative care team to ensure co-ordinated care was in place for patients who were nearing the end of their life. 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.

Four staff were trained and responsible for patient referrals to other services and 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. They also arranged transport for patients and liaised with them for attending appointments.

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.

For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Consent to care and treatment

Staff demonstrated an understanding of the principles of gaining consent including issues relating to capacity in line with the Mental Capacity Act 2005. GPs were able to outline a mental capacity assessment they would use to support them in making assessments of a patient's capacity and outlined the need to keep clear records where decisions were made in the best interest of patients. This showed us that staff were following the principles of the Mental Capacity Act 2005 and making detailed records of decisions to ensure patients or relatives were involved in the decision making process.

All staff we spoke with made reference to Gillick competency when assessing young patients. The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. We were told this would be recorded within the patient's record. We were shown an example when a young patient, who had a long term condition, requested to stop taking a specific medicine. The GP assessed this person's capacity to make this decision and understood the consequences of it. This patient asked the GP to inform their family of the decision which the GP did.

We were shown forms for which consent other than implied consent would be recorded. This consent form, once signed would be scanned into patients' notes.

Health promotion and prevention

All new patients who registered at the practice were asked to complete a health questionnaire. This information was then entered into the patient's record. If any concerns were

Are services effective?

(for example, treatment is effective)

identified or the patient had a pre-existing medical condition or if the patient requested a health check the GP was informed and an appointment made to see the GP or nurse as appropriate. We were told about a situation where two patients registered with the practice and received a health check. Tests found that one of these patients had type II diabetes. As a result of the health check the person was immediately referred to a specialist nurse at the practice for appropriate treatment and support.

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. The practice offered a number of health promotion services which included pre conception, stop smoking, obesity and maternity clinics.

The practice offered health checks to patients aged between 40 and 75. During the previous 12 months 312 patients came forward. The practice was unable to tell us how many had been invited as this was a Public health England initiative.

All of the 85 patients with a learning disability were offered an annual health check and 39 took this up so far since April 2014. We were told that those who had not received a health check would be invited to attend in March 2015.

Smoking cessation support was offered to patients who signed up to the Quit4Life programme. Of the 22 who started this programme it was reported that 10 patients had successfully stopped smoking. The practice recognised that the number was low and intended to promote the service.

We saw information about other national programmes which included bowel and breast screening. For example, 71% of those invited for bowel screening took this up and 82% of patients eligible for breast screening had been screened so far this year. We were unable to compare these figures to local and national figures as the current year had not ended.

However, when comparing the previous year we saw that the practice performed above both the local and national average for cervical screening and for patients who received the flu vaccination who were either over the age of 65 years of age or in an at risk group.

The practice also offered a full vaccination program for all children who were registered. This included Measles, Mumps and Rubella (MMR), Polio and Tetanus. We were told that out of the 604 two year old children registered 595 (98.8%) received the recommended vaccinations for their age.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the results of the most recent GP patient survey, published in January 2015. Results showed the practice was rated above the local clinical commissioning group and national patient satisfaction by patients who were asked about how they were treated by GPs and nurses. Of the patients asked, 87% said they felt GPs treated them with care and concern and 84% said they felt nurses treated them with care and concern.

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 and was shielded by a glass partition 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. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were polite, friendly and helpful. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with nine patients 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.

Care planning and involvement in decisions about care and treatment

We reviewed data from the same national patient satisfaction survey which showed the practice was rated above the local and national patient satisfaction average when asked if they were involved in decisions about their care and whether the GP was good at explaining tests and treatment. Of the patients asked, 79% said that they felt the GP involved them in decisions about their care and 86% said the GP was good at explaining tests and treatment.

Patients were made aware of the options, services and other support available to them. We spoke with staff who confirmed that discussions took place about these options which enabled patients to make informed choices. Information was given verbally, via leaflets, printed by the GP and from the practice website.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that staff understood patient's personal circumstances and were better able to respond to their emotional needs.

Staff told us GPs made contact with the bereaved relative/spouse when they were made aware that the patient had died. This was also confirmed by the GPs we spoke with.

Information in the patient waiting room and the practice website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an understanding of its patient population, and made adjustments to respond to patient's needs. Longer appointments were given to older, frail and patients with poor mental health. The practice also offered specialist clinics which included; insulin conversion, learning disability, asthma and contraception.

Patients could order repeat prescriptions and book appointments with a GP over the internet. Patients could also ask for appointment reminders and blood test results via SMS text message.

The practice was proactive in working with patients and their families. They worked closely with other providers in providing palliative care and ensuring patient's end of life wishes were recorded and shared with out of hours providers.

The practice had a proactive patient participation group (PPG). We met with two members of the PPG who were positive about the practice and told us they felt welcomed and involved in the development of the practice. Following patient feedback the practice changed the way appointments could be arranged. Patients calling the practice were given an option to have a same day telephone consultation instead of waiting for a face to face appointment.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice was accessible to disabled patients who required level access. We saw disabled person's parking spaces positioned close to the entrance door which had an electronic opening facility.

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.

The practice was spacious and uncluttered throughout. Treatment rooms were large which made them accessible to wheelchairs and prams.

Patients who experienced poor mental health were offered support both at the practice and from external organisations which included a consultant psychiatrist, counsellor and iTalk. Longer appointments were also offered for these patients.

Practice staff had access to interpreting services, via language line and there were facilities for patients to translate the practice website into 91 different languages. A number of patients were Nepalese or Polish. We were told that these patients attended their appointments with a translator Or their family who attend and can translate on their behalf. The practice also had a regular intake of temporary patients. These could be students returning home for the holiday or family members visiting an elderly relative. Homeless people could also receive emergency treatment for up to 14 days but after this needed to become registered as a temporary resident.

Access to the service

We looked at the results of the most recent GP patient survey, published in January 2015. Results showed the practice was rated above the local clinical commissioning group and national patient satisfaction. Patients were asked how convenient their last appointment was. Of the patients who responded, 93% said it was convenient and 81% said they found it easy to get through to the surgery by phone.

Surgeries were held between the hours of 9:00am and 12:00noon and 2:30pm and 6:00pm from Monday to Friday. Nurse clinics were held daily between the hours of 8:00am and 5:30pm. Early morning GP surgeries were held on Tuesdays and Fridays and evening surgeries on Wednesdays. Saturday morning GP and nurse surgeries were held on alternate weekends.

Home visits were available for patients who were housebound because of illness or disability.

Appointments could be made by telephone, on line or in person. The practice also offered a telephone consultation service. This involved a GP telephoning a patient back to discuss their medical issue. These consultations could be made on line. Patients were given information, via the practice website, about when a telephone consultation may be used. Examples included explanation of test results, advice concerning minor illness, advice concerning medicines and changes to medicines and certification where surgery attendance was not required.

Are services responsive to people's needs?

(for example, to feedback?)

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours (OOH) service. If patients called the practice when it was closed an answerphone message gave the telephone number they should ring depending on their medical symptoms. Information about the OOH service was also provided to new patients via patient information packs and displayed on the practice website.

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.

Information about how to make a complaint was displayed in the waiting area and available on the practice website and in the practice leaflet. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

We reviewed the complaints folder that contained details of all complaints raised. All 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. One was about a communication error and the other about customer service. Both included communication with the complainant to acknowledge the complaint and apologise. This was done by letter. We saw clear evidence in the way of letters, screen printouts and results that both complaints had been fully investigated, resolved and learning shared with relevant staff as appropriate.

Are services well-led?

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

Our findings

Vision and strategy

We spoke with 14 members of staff who all expressed their understanding of the core values of the practice and provided us with a wide range of examples to demonstrate their commitment to providing high quality care and support to their patients. We saw evidence of the latest guidance and best practice being used to deliver care and treatment.

GPs met regularly to plan the vision of the practice. The practice had a development plan which ran from 2002 to 2015. We saw that the previous year's plans were reflected upon and the plan adjusted as necessary the following year. The lead GP told us about the succession plans that were in place for those GPs who would be reducing their involvement at the practice. This involved up-skilling a number of staff to attend to administrative matters the GPs currently dealt with. The long term aim of the practice was to expand on its current site to accommodate patients living in new housing in the local area. Planning for 2015 included upgrading the premises to accommodate new services. For example, converting a small staff room into a treatment room for podiatry and dressings.

Governance arrangements

We saw a number of practice policies and protocols. These were reference guides for nurses and GPs to use in the care of patients. The practice used a commercial toolkit for creation of its policies. This toolkit provided a comprehensive list of documents which were tailored to the practice's requirements. Examples of policies seen included; health and safety, complaints, recruitment, consent, safeguarding and information governance. All the policies viewed had been reviewed in November 2014 by the lead GP.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the national average. We saw that QOF data was regularly discussed at QOF specific team meetings and action plans were produced to maintain or improve outcomes.

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.

Most areas of safety were monitored and discussed routinely but areas such as infection control, medicines management and requirements relating to workers were not.

Leadership, openness and transparency

There was a clear leadership structure at the practice. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Most of the team had worked together for many years and there was a very low turnover of staff. They told us that teamwork was very important and they felt as a team they were very effective in delivering high quality care. Staff met informally at practice arranged social events such as summer BBQs and Christmas parties.

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

We looked at the results of the most recent GP patient survey, published in January 2015 and 77% of patients who responded said they would recommend the practice to someone new to the area.

All the staff spoken with told us they felt engaged with the practice. They all referred to the GPs by their first name and clearly felt comfortable communicating with them. They also had access to the practice manager and told us that they were able to express ideas and concerns. The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice.

Meetings were held weekly that all staff were invited to attend. Primary health care team meetings (PHCT) were held quarterly and all members of staff were invited to attend. Various agenda items were discussed at each meeting. We viewed minutes and agendas which confirmed this.

The practice had an active patient participation group (PPG) who met every three months. The group was made up of approximately 15 patients and staff. A GP always attended meetings and the practice manager supported the group by taking minutes. Patient surveys were carried out face to face, by post, online, at flu clinics and mother and baby clinics. Feedback from a previous survey that asked how the practice should communicate best with patients indicated that they preferred newsletters in the waiting room and local magazines. The PPG developed a communications sub group to take this forward.

Are services well-led?

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

Other changes made as a result of feedback was the introduction of a new telephone appointment system, staff training in customer service, appointment SMS text message reminders and on-line repeat prescription request service.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Annual appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development opportunities.

GP trainees felt supported and properly mentored. We looked at their appointments list and saw there was always one or two GPs rostered with free time to mentor them. GPs had one week's study leave per year.

There were arrangements in place to manage staff performance. Staff told us that they could contribute their views to the running of the practice and that they felt they worked well together as part of the practice team to ensure they continued to deliver good quality care. The practice took account of complaints to improve the service and significant events were discussed and learnt from through regular quality meetings.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>A legionella risk assessment had not been undertaken and chemicals used for cleaning the practice were not stored in a secure manner. An annual infection control statement had not been written.</p> <p>This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The registered person must –</p> <p>Ensure the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Medicines such as vaccinations were stored in fridges and cupboard which was not locked which meant that these were accessible to unauthorised people.</p> <p>This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(f and g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The registered person must –</p> <p>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.</p>

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

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 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person must –

Ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate.