The Waterfield Practice

Quality Report

The Waterfield practice, Ralph's Ride,
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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?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of The Waterfield practice on 15 October 2014. We visited The Waterfield practice**,** Ralph's Ride, Harmanswater, Bracknell, RG12 9LH. We did not visit the branch site at 1 County Lane, Warfield, Bracknell, RG42 3JP during this inspection. The practice is rated as requires improvement. Although many aspects of the practice were good, improvements in the domains of safe and well-led were required.

Our key findings were as follows:

Patient feedback from surveys, comment cards and verbal feedback was very positive. The majority of patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. The appointment system was robust and offered both online and telephone booking for patients. Appointments could also be booked in person. Patients with limited mobility were able to access the practice. There were concerns regarding the identifying and delivery of training required by staff. Some staff did not receive all the training they needed to provide safe and effective care.

The practice followed clinical guidelines. There were care planning arrangements for the management of different health conditions. There were arrangements to ensure vulnerable patients received the care and treatment they needed. There was evidence that the practice was extremely compassionate and caring. The practice had a clear leadership structure and an open and transparent culture. Staff were valued, supported and their views were considered in the running of the practice.

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

Importantly, the provider must:

Summary of findings

- ensure that training and development needs are identified for all staff to deliver safe, effective and responsive care to patients. For example, equality and diversity, information governance training and Mental Capacity Act (2005)
- review its recruitment processes to ensure all information required including background checks is up to date.
- implement monitoring systems for hygiene and infection control, including a system of audit, identifying and assessing any risk of legionella and cleaning check system to ensure relevant guidance is followed by staff.

We have issued three compliance actions for the regulation relating to the Requirements of Relating to Workers, Supporting Workers and Hygiene and Infection Control.

In addition the provider should:

- provide health checks to new patients.
- review how all staff are involved in the management and clinical governance of the practice.

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 safe as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Incidents were reported investigated and action taken to reduce the risk of them recurring. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented consistently to ensure patients were kept safe. Safeguarding training was not up to date for many staff and some staff were not aware of where safeguarding policies were kept. There was no formal training programme for hygiene and infection control. We found the practice was clean and hygienic. Clinical waste was disposed of appropriately. Medicines were stored and monitored properly. There was no monitoring system for hygiene and infection control.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff received training appropriate to their roles and further training needs had been identified and planned. The practice did not manage staff training. For example there was no training in equality and diversity, information governance and there was no means of ensuring that staff had an appropriate awareness of the Mental Capacity Act (MCA) 2005. The practice was able to identify all appraisals and personal development plans for all staff. Multi-disciplinary working was evidenced. Health promotion and systems to manage health were in place including registers for specific health conditions.

Are services caring?

Good

The practice is rated as good for caring. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. For example, we were told about two cases where staff had provided treatment beyond the responsibility of the practice to promote patients' independence and protect them from distress. We found positive examples to demonstrate how patients' choices and preferences were valued

Summary of findings

and acted on. Data showed patients rated the practice higher than others for several, but not all, aspects of care. Feedback from patients about their care and treatment was consistently and at times strongly positive.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available the same day. The practice had appropriate facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. There was a clear leadership structure and staff felt supported by management. Staff told us there was a very positive, open and transparent culture and staff were proud to work at the practice. The practice had a number of policies and procedures to govern activity and regular meetings took place. However, there was no whistleblowing policy. There were systems to monitor and improve quality and identify risks. The practice proactively sought feedback from staff. The practice was in the process of reforming its patient participation group (PPG) and there was no completed practice survey from 2014. There was a current survey underway.

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 provided health checks and immunisations to older patients in line with national guidelines. The practice was considerate and caring towards older patients. The premises were suited to patients with limited mobility. Staff had access to a palliative care register and they held regular multi-disciplinary case review meetings where all patients on the palliative care register were discussed. The practice did not ensure that staff awareness of safeguarding and the Mental Capacity Act 2005 was maintained to protect patients against abuse and ensure their rights were protected when they lacked capacity to make certain decisions. The uptake of the flu vaccine among patients over 65 was 71% which matched the national average.

People with long term conditions

Good

Periodic reviews of conditions were offered to patients with health conditions. National data showed the practice performed well in meeting the needs of patients with long term health conditions. External services were consulted and included in patients' care. Flu immunisations were offered to patients who were in the at risk groups eligible for the immunisation. The uptake of flu vaccines for patients at risk of serious health problems associated with flu, below 65 years old was 45% which is slightly below national average. The practice identified patients who had long term conditions or were on multiple medicines to ensure their care and medicines were reviewed regularly. Asthma and chronic obstructive pulmonary disease (COPD) patients had their annual reviews during summer months as this was the best time of the year to undertake these health checks.

Families, children and young people

Good

The practice provided prenatal and postnatal clinics to mothers and babies. The midwife who visited The Waterfield Practice told us the practice worked well in caring for babies and mothers. Health information and support was available for young people. The practice was accessible for patients attending with buggies and prams. GPs were aware of the Gillick principles of gaining consent from patients under 16. The practice discussed children who were on the at risk register with the local authority to ensure staff were aware of potential issues related to the child's safety and wellbeing. There was a policy to prompt patients to have a cervical smear unless they opted out of the programme. The policy stated that patients who had opted out were sent a letter offering the chance to

Summary of findings

have a cervical smear every five years. The practice website offered support and advice for teenagers and young patients on sexual health, substance misuse and emotional concerns including a local counselling service for patients aged 12-25.

Working age people (including those recently retired and students)

Good

There were extended hours appointments available. An online appointment and prescriptions service was available and these services were convenient for patients who worked. Some patients reported that making appointments via the phone system was difficult, particularly for those of working age who could not call at 8am. There was information for self-care available on the practice website, meaning patients did not need to attend the practice for certain ailments. Phone consultations were available to all patients. The practice did offer NHS health checks to all its patients aged 40-75. The practice had identified the smoking status of 82% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. Appointments for travel vaccinations and weight management were available. A social media service was set up by the practice to support patients by providing health advice online.

People whose circumstances may make them vulnerable

Good

The practice maintained registers for patients in vulnerable circumstance, such as a learning disability register. We were informed of occasions when staff had gone beyond their duty of care to provide treatment which assisted vulnerable patients For example, a GP provided urgent treatment to a very vulnerable patient to prevent them from needing to attend A&E. Another vulnerable patient was able to fulfil a personal ambition they could not have done without a GP's support provided during travel. The practice did not ensure that staff awareness of safeguarding was maintained through training to protect patients against abuse. Carers were supported by the practice and signposted to external support organisations. The computer system alerted GPs if a patient was also a carer. There was a carer's register and carers were signposted to national carers' association websites. A local practice hosted carers' evenings and these were promoted actively by the practice. The practice was part of the Harmanswater good neighbour's scheme, which assisted local people who required help in daily life and a local befriending service for people who may suffer from social isolation. The website was translatable into 50 different languages.

Summary of findings

People experiencing poor mental health (including people with dementia)

The practice worked closely with local mental health services. There were arrangements to ensure referrals to these services took place, including provision of some services within the practice. Staff received some but not all training to ensure that patients' rights were protected when they may have lacked capacity to consent to care. 'Talking-Therapies', provided by a local mental health service, was provided within the practice making it accessible to patients. The practice enabled patients to self-refer to the service. Quality Outcome Framework (QOF) data showed the practice monitored the health and wellbeing of patients who experienced poor mental health. This included regular medicine checks and physical health checks.

Requires improvement 

Summary of findings

What people who use the service say

During the inspection we spoke with eight patients and received feedback from 14 comment cards. Patients reported staff were compassionate, caring and courteous. Feedback suggested patients were well cared for by the practice. Most patients told us they were able to make an appointment or speak with a GP when needed. There was some flexibility in appointment times and which GP they saw. Some patients told us there were problems in getting through on the phone to make an appointment in the mornings and others told us they found it difficult to get an appointment. Patients found communication from the practice helped them to manage their care and access to advice and treatment. This included reminders to attend for health checks and text reminders about appointments. Patients were involved in decisions about their care and treatment and provided with information to manage their care.

We looked at the GP national survey results from 2014 to which there were 180 responses. Seventy five percent said the last nurse they saw or spoke with and 81% said the last GP they saw or spoke with was good at treating them with care and concern. The evidence from all of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 74% of practice respondents said the GP involved them in care decisions (this was above the CCG average) and 76% felt the GP was good at explaining treatment and results (this was below CCG average).

Areas for improvement

Action the service MUST take to improve

- ensure that training and development needs are identified for all staff to deliver safe, effective and responsive care to patients. For example, equality and diversity, information governance training and the Mental Capacity Act (2005)
- review its recruitment processes to ensure all information required including background checks is up to date.
- implement monitoring systems for hygiene and infection control, including a system of audit, identifying and assessing any risk of legionella and cleaning check system to ensure relevant guidance is followed by staff.

We have issued two compliance actions for the regulation relating to Supporting workers and Hygiene and Infection Control.

Action the service SHOULD take to improve

- offer health checks to new patients
- review how all staff are involved in the management and clinical governance of the practice.

Outstanding practice

The Waterfield Practice

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 adviser and practice manager.

Background to The Waterfield Practice

The Waterfield Practice is located on two sites and has a patient population of approximately 12,000. The Ralph's Ride practice has treatment and consultation rooms on the ground floor with wheelchair access at reception. There are six partners and a total of eight GPs working at the practice, as well as locums. There are two male and six female GPs working at the practice. The nursing team consists of five practice nurses and one healthcare assistant. Administrative and reception staff also work at the practice. The Waterfield Practice is a training practice.

The practice has a General Medical Services (GMS) contract. GMS contracts are subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the British Medical Association.

This was a comprehensive inspection.

We visited The Waterfield practice**,** Ralph's Ride, Harmanswater, Bracknell, RG12 9LH as part of this inspection.

We did not visit the other site at Warfield Green Medical Centre, 1 County Lane, Warfield, Bracknell, RG42 3JP.

The practice has opted out of providing Out Of Hours services to their patients. There are arrangements in place for services to be provided when the practice is closed and these are displayed at the practice and on the website.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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), Bracknell Forest Healthwatch, NHS England and Public Health England. We visited The Waterfield Practice on 15 October 2014. During the inspection we spoke with GPs, nurses, the practice manager, reception staff and patients. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

- 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

The practice population had low economic deprivation and lower than average long term health conditions. The age spread of patients largely matched the national population profile. There was a slightly higher proportion of patients from the age of 40-55 years old.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and comments and complaints which had been received from patients. Staff we spoke with were aware of their responsibilities on how to raise concerns, and how to report incidents and near misses. For example, in May 2014 a prescription of antibiotics was issued without seeing or speaking to the patient. The practice identified and acted quickly to rectify the incident. The practice had not raised any safeguarding alerts within the last year.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the clinical meeting agenda and significant events were discussed periodically to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. We tracked eight significant events from this year and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. The number of significant events identified by the practice was low considering the practice had a population of over 12,000 patients. The practice partners and manager suggested that this was because they considered serious incidents as significant events, rather than any incident where there may be a learning outcome. We saw team meeting minutes where incidents or learning outcomes which were not significant events were discussed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. There was a safeguarding adults and children policy. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. GPs and nurses were able to name the practice's safeguarding lead. The practice training matrix made available to us showed that five nurses, three GPs and the practice manager were overdue training on safeguarding adults and children. Several reception staff were overdue training in safeguarding children and adults and were not aware where to find the safeguarding policies. Staff were not aware of where safeguarding policies were stored.

The practice had a dedicated GP appointed as a lead in safeguarding vulnerable adults and children who had been trained to the necessary level to enable them to fulfil this role. All staff we spoke with were aware who the lead was 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 so staff were aware of any relevant issues when patients attended appointments. For example children subject to child protection plans.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone a member of the administration team had also undertaken chaperone training. Staff told us another member of administration staff had undertaken the role of chaperone and there was no evidence they had received training.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called EMISweb which collated all communications about the patient including scanned copies of communications from hospitals. This included flags on relevant patient information, such as significant health conditions or allergies.

The practice discussed children who were on the at risk register with the local authority to ensure staff were aware of potential issues related to the child's safety and wellbeing. A&E attendances were also discussed at staff meetings to identify if there were trends with specific patients that could indicate any problems affecting safety. The practice identified patients who had long term conditions or were on multiple medicines to ensure their care and medicines were reviewed regularly.

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

clear process for ensuring medicines were kept at the required temperatures. Medicines fridges had alarmed thermometers to alert staff if the temperature medicines were stored at was outside their required storage range. Processes were in place to check medicines were within their expiry date and suitable for use. All of the medicines we checked in five consultation and treatment rooms were within their expiry dates.

We saw records of practice meetings that noted the actions taken in response to review of prescribing data. For example, audits on antibiotic and hypnotics prescribing were undertaken within the practice and the audit loop was closed to identify if the practice had improved based on learning outcomes. Incidents related to medicine errors were acted on promptly with robust action to remedy the problem and reduce the risk of reoccurrence.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. A member of the nursing staff was qualified as an independent prescriber.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. We discussed the system for repeat prescriptions with a GP partner. They told us dedicated prescription clerks produced the prescriptions. All patients taking regular medicines had at least an annual review, unless the patient took medicines which required more frequent reviews or had special instructions. GPs reviewed letters from hospital consultants where requests for changes to prescriptions were required. The GP told us reception would be telephoned regarding changes to prescriptions and if patients were not contactable, a note was left on patient records for GPs to discuss with the patients when they were next seen.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We looked at six clinical treatment and consultation rooms. They were all clean and hygienic. We noted there were no cleaning schedules and no cleaning records were kept. Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control. There was no formal training programme for staff regarding hygiene and infection control and staff told us they had not received any recent training. There was no hygiene and infection control audit undertaken to ensure all relevant guidance was followed or areas of risk identified. We saw the practice had identified improvements to manage infection control. For example, sharps bins were colour coded with information on what each one should be used for and they were within their maximum fill. However, not all guidance was followed. Sharps bins waiting for collection from external contractors were stored in area accessible to patients. There was the potential risk that patients, specifically children, could access the area and sustain a sharps injury if they picked up the boxes. Some clinical waste bins were not pedal operated, which could pose a minor infection risk.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury, however this was not displayed in clinical rooms should it be required quickly by staff.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice manager stated there were no cooling systems in the building, but was not certain whether there was a cold water tank, which could pose a potential legionella risk. The practice did have a hot water cylinder.

Equipment

We saw equipment which enabled staff to provide safe care. Medical equipment was stored in treatment and consultation rooms securely. Maintenance and calibration of medical equipment was undertaken. All medical portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. However, non-medical equipment did not receive regular testing. Practices need to risk assess and hold a register of portable appliance testing on their equipment.

Staffing & Recruitment

The staff records we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification,

qualifications, registration with the appropriate professional body. However, there was no written proof of conduct in the staff records from their previous health or social care roles. The manager explained verbal references were sought from previous employers. The practice had a recruitment policy that set out the standards it followed when recruiting GPs, nurses, administration and reception staff. Three members of nursing staff did not have a disclosure and barring service (DBS) check (this replaced the criminal record bureau or CRB checks). We saw evidence that the practice had applied for DBS checks on the three nurses recently and were waiting for the disclosures to be returned. The practice did not have a policy or risk assessment to determine how often staff DBS or CRB checks needed to be renewed. DBS guidance suggests practices risk assess how often a staff member has their DBS renewed based on the role and contact with vulnerable patients. Hepatitis B vaccination records were present in the staff files we checked.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice manager told us they worked with receptionists to identify the demand for appointments and phone consultations. The practice altered the number of staff answering phones and GP appointments in response to this.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. The building and environment were well maintained and safe. Medicines and medical equipment were stored securely and checked regularly to keep them safe. The practice also had a health and safety policy. The practice had a fire risk assessment which identified actions to improve fire safety. The action plan was due to be completed in the coming months. The practice computer system had a means of alerting all staff working that there was a potential emergency. This enabled staff to respond quickly to emergencies and protect patients and staff. There was a control of substances hazardous to health (COSHH) risk assessment available for the storage of cleaning chemicals in the practice.

Information from data monitoring systems such as the Quality and Outcomes Framework (**QOF**) which is a voluntary system for the performance management and payment of GPs in the National Health Service showed the practice monitors the health and wellbeing of patients who experience poor mental health. This included regular medicine checks and physical health checks.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all nurses and GPs had received training in basic life support. Some administration staff had not received basic life support training but the manager and partners told us there was always a GP or nurse on duty when patients attended the practice. 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). All of the staff we spoke with knew the location of this equipment and records we observed these were checked regularly. There was guidance for various types of medical emergency stored with the equipment for staff to refer to.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of common emergency conditions. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan had been implemented to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included events such as power failure, unplanned sickness and access to the building. The practice had reciprocal arrangements with another local practice to enable the practices to continue providing patient care in the event of emergencies which prevented premises from being accessed. The manager told us they were in the process of creating an adverse weather plan.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. The practice was undertaking care planning for patients who may be at risk of admission to hospital as part of an enhanced service. This was a voluntary scheme which benefitted patients by implementing better care planning.

The GPs told us they lead in specialist clinical areas such as diabetes, ear nose and throat (ENT) and arthritis. The practice nurses had training in supporting the care and treatment for specific health conditions. GPs and nurses staff we spoke with were very open about asking for and providing colleagues with advice and support. The review of the clinical meeting minutes confirmed staff discussed national best practice in their approaches to patient care.

The senior GP partner showed us audits including the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multi-disciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed by their GP according to need. The practice told us they did not review every patient who had been discharged from hospital but did ensure GPs were made aware of discharge notes. We saw an example of a patient discharged from hospital in September 2014 with several health conditions. The GP documentation following discharge was robust and follow up plans were put in place to ensure the patient was well cared for.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for referrals. We saw minutes from weekly meetings where all non-urgent referrals were made. The GPs told us they were open and challenging about each other's referrals. They said this enabled them to ensure that only appropriate referrals were made. This process also allowed referrals which could be dealt with by GPs with a specialism to be referred within the practice, reducing patients' waits for secondary care, such as hospital appointments.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had processes to monitor and improve outcomes for patients. These processes included input of patient information on the computer system for nurses and GPs to access, clinical review scheduling, patient register management and medicines management. There was evidence that the practice was proactively looking at improving the service they provide to patients. For example they were thinking of complex care clinics, Saturday morning surgery provision and 20 minute consultations for people with long-term conditions. Some of these would be dependent on additional funding from the Clinical Commissioning Group (CCG) or through federation with other practices in the CCG. We saw evidence of peer review within the locality on referrals, first outpatient appointments, unplanned admissions and accident and emergency attendances.

The practice showed us 15 clinical audits that had been undertaken in the last two years. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. We saw examples of completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, a cancer diagnosis audit was a completed audit from March 2013 which was initially undertaken in

Good

Are services effective?

(for example, treatment is effective)

January 2011. We saw improvements were put in place to improve patient outcomes. We looked at an audit on treatment for chronic kidney disease. The re-audit identified that nearly all patients included in the initial audit had appropriate testing of their kidney function within the designated timeframes. Not all patients had been re-checked in the second audit. We saw evidence that nurses were involved in identifying and undertaking audits especially in their areas of expertise as was the case with the diabetes nurse.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the practice was significantly above average on three indicators of their diabetes care standards and met national averages on other diabetes indicators. The practice met the national average for reviewing patients with asthma. The practice achieved 99% on their 2012/13 QOF score, which was above the national average.

The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. This happened in weekly clinical meetings, but they were not attended by a member of the nursing team. A GP partner explained the practice would start to include nurses in these meetings in the near future. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all GPs and nurses should understand audit outcomes and participate where relevant to their role.

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 the latest prescribing guidance was being used.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed a training record of annual basic life support and all medical staff were up to date. Some administrative staff had not received basic life support in the last year, but there was always a member of medical staff on duty at the practice sites. A broad skill mix was noted amongst the GPs. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation (Every GP is appraised annually and every five years undertakes a fuller 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).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing clinical training and funding for relevant courses. Staff said they had the opportunity develop in their roles as clinical leads by attending specific training. However, some staff told us it had been difficult to gain the training they wanted because the practice had been required to reduce the training days to two per year. The practice did not have a monitoring tool which identified all the core training needs and how often staff should undertake training. For example, there was no training programme in the Mental Capacity Act 2005 (MCA), hygiene and infection control equality and diversity or information governance. Staff folders did not contain evidence that this training had been undertaken.

The practice mentored GPs trainees. Feedback from a trainee we spoke with was very positive. They told us they felt extremely well supported by the practice and were given protected learning time.

Practice nurses had defined duties they were expected to perform, including caring for patients with long term conditions. Nurses told us they had training on administration of vaccines, asthma clinics and chest clinic updates.

Working with colleagues and other services

The practice worked with external services such as district nurses and health visitors. There was a regular multi-disciplinary team meeting where patients receiving end of life care or cancer treatment could be discussed. The partners told us this meeting was restricted due to a number of external professionals who could not attend including the local social care team and mental health services. We saw minutes from joint practice meetings which were attended by various staff from GP practices in the area, social workers and other healthcare professionals. Patient care was discussed and actions identified to improve meet the patients' needs. The practice discussed prenatal and postnatal care with the midwife who provided clinics at the practice. A GP explained they would discuss difficult pregnancies or families with children on the at risk

Good

Are services effective?

(for example, treatment is effective)

register with the midwife. GPs told us they communicated with consultants regarding patients' care. They had access to a service where patient care and treatment could be discussed without the need to refer patients. Any discharge summaries sent to the practice regarding patients sent home from hospital were stored on the practice's patient record system and reviewed by GPs.

Information Sharing

The practice had systems to share information securely between staff. GPs and nurses could access patients' notes made by other GPs. This enabled GPs to provide continuity in care and treatment. The GP partners told us they received patients' discharge records from secondary care services. The practice had a system which worked in tandem with local hospitals to provide this information to the relevant GP for any follow up care to be completed. There was a system in place with the local out of hours provider to enable patient data to be shared in a secure and timely manner. This was limited due to the different computer software used. Electronic systems were used for making referrals.

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

Consent to care and treatment

Staff we spoke with told us they would obtain consent to treatment from patients. The practice had a clear process for recording consent for some procedures, such as minor surgery, but not for all procedures. Staff told us consent for some procedures was verbal. We saw evidence of patients being involved in decisions about their care and treatment.

We asked GPs and nurses whether they had an understanding of the Mental Capacity Act 2005 (MCA) and Gillick principles. Although staff were aware of the MCA some staff did not fully understand the circumstances when it should be used to assess capacity or the principles for doing so. Some nurses and GPs did not understand the terminology of a best interest decision (a decision made on someone's behalf if they lack the capacity to do so). Two GPs we spoke with told us the practice had two members of staff who had a very robust understanding of the MCA. They said staff would speak with them if they had concerns regarding consent. A nurse we spoke with confirmed they would speak with GPs if they encountered situations with patients where the MCA or Gillick principles may have been required. We saw no evidence of training or a policy for staff on the MCA. Although some staff had a clear and thorough understanding of the MCA and Gillick Principles, the practice had not ensured all staff had a sufficient awareness and protocols to follow in order to protect patients' rights in respect of the MCA.

Health Promotion & Prevention

It was not practice policy to offer all new patients registering with the practice a health check with a practice nurse. The practice did offer NHS health checks to all its patients aged 40-75. The practice had numerous ways of identifying patients who needed additional support, and were proactive in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were offered annual reviews for clinical and mental well-being. The learning disability register was shared not only with the GPs and nurses but also with a locality learning disabilities team so the information could be cross-referenced and kept up-to-date.

The practice had identified the smoking status of 82% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. Clinics for cervical smears, travel vaccinations and weight management were available. The practice had a policy to prompt patients to have a cervical smear unless they opted out of the programme. The policy stated that patients who had opted out were sent a letter offering the chance to have a cervical smear every five years. The practice had a palliative care register and held regular multi-disciplinary case review meetings where all patients on the palliative care register were discussed.

The practice offered a full range of immunisations for children, travel vaccinations and flu immunisations in line with current national guidance. Last year's performance for child immunisations matched the local average or exceeded it. The uptake of flu vaccines for patients at risk of serious health problems associated with flu, below 65 years old was 45% which is slightly below national average. The uptake among patients over 65 was 71% which matched the national average. Patients with long term medical conditions were offered regular health checks during dedicated appointments to ensure their health needs were robustly assessed and managed. QOF outcomes suggested

Good

Are services effective?

(for example, treatment is effective)

the practice performed well in providing health checks to patients with long term health conditions. Asthma and chronic obstructive pulmonary disease (COPD) patients had their annual reviews during summer months as this was the best time of the year to undertake these health checks. The practice provided annual health checks to patients suffering from poor mental health.

The practice website offered support and advice for teenagers and young patients on sexual health, substance misuse and emotional concerns.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We looked at the GP national survey results from 2014 to which there were 180 responses. Seventy five percent of patient responding said the last nurse they saw or spoke with and 81%said the last GP they saw or spoke with was good at treating them with care and concern. The evidence from this source showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 14 completed cards and the majority were positive about their experience and the care and treatment they received. Patients said they felt the practice offered a friendly, helpful and caring service. They said staff treated them with dignity and respect. We spoke with eight patients during the inspection and the responses from most patients were very positive. Two comments were less positive regarding how reception staff spoke with patients, but most feedback regarding the reception staff suggested they were helpful and courteous. All patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The reception area was open and close to the waiting area. We observed that some conversations could be overheard by patients waiting for their appointments. The reception staff spoke quietly to protect patient's privacy. Patients were not concerned about the layout of the waiting area and reception. Staff told us they would provide private rooms if patients wanted to discuss sensitive information.

Staff acted with empathy and compassion with patients in vulnerable circumstances. Staff told us of colleagues who had gone beyond their caring responsibilities to assist patients. For example, a GP provided emergency treatment to a patient experiencing poor mental health to prevent them from needing to attend A&E. Going to hospital could have caused distress and worsened the patient's mental state. Another patient with a long term medical condition which affected their independence was supported by the practice to acquire equipment to help them live more independently. A GP provided exceptional support to the patient to help them live according to their beliefs and wishes. They accompanied the patient on a trip, which held huge significance to the patient, to provide the care and treatment they required while travelling. The practice was part of the Harmanswater good neighbours scheme, which assisted local people who required help in daily life.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 74% of practice respondents said the GP involved them in care decisions (above the national average) and 76% felt the GP was good at explaining treatment and results (below the national average).

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. We saw an example in records belonging to a patient in vulnerable circumstances due to their long term condition deciding against a particular treatment and the practice had recorded and respected this decision.

Staff told us that translation services were available for patients who did not have English as a first language. However, there were no notices in the reception area

informing patents this service was available. GPs told us they had offered and used this service for patients. The practice website was translatable into 50 different languages.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The practice website and reception television screen signposted people to a number of support groups and organisations. This included a local befriending service, a counselling service for patients aged 12-25 and carer support. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice had a carer's register and carers were signposted to national carers association websites. A local practice hosted carers' evenings and these were promoted actively by the practice. 'Talking-Therapies', provided by a local mental health service, was provided within the practice making it accessible to patients. The practice enabled patients to self-refer to the service. A social media service was set up by the practice to support patients by providing health advice online. Staff told us this has proved popular with patients.

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 people's needs and had systems to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

There had been very little turnover of staff during the last six years which enabled continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people 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, such as older patients or those with disabilities which made it difficult to attend the practice. Telephone consultations enabled patients who may not need to see a GP the ability to speak with one over the phone. This was a benefit to patients who worked full time or could not attend the practice due to limited mobility. There were regular internal as well as multi-disciplinary meetings to discuss patients' needs. The practice worked collaboratively with other care providers such as district nurses. The practice worked collaboratively with other agencies and regularly shared information with the out of hours service and local hospitals to ensure timely communication of changes in care and treatment.

The practice had implemented suggestions for improvements made by patients in relation to the appointment system. Two years ago the appointment system was changed. There was no patient feedback on the appointment system changes to identify what patients thought of the change. Most patients were satisfied with the appointment system although they told us it was sometimes difficult to get through to the practice by phone.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multi-disciplinary meetings to discuss patient and their families care and support needs.

The practice advertised external services such as mental health support services in the waiting area. Support groups and external services were advertised on the website, such as new parent groups. There was no information on the website about local mental health, counselling or drug and alcohol services for patients.

There was an online repeat prescription service. This enabled patients who worked full time to access their prescriptions easily. Patients could also drop in repeat prescription forms to the practice to get their medicines. Patients told us the repeat prescription service worked well at the practice. The practice referred certain prescriptions to pharmacies that deliver for patients who found it difficult to collect their prescriptions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice was aware of a growing number of patients whose first language was not English and the practice had a translation service they were able to access. The premises were adapted to meet the needs of people with disabilities. There were two entrances to the practice with ramps and wide doors. There was a lowered section of reception desk for wheelchair users to be able to speak with receptionists. 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 8am to 6.30pm on weekdays. The practice provided extended hours appointments on Monday evenings until 7.30pm. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. The practice allocated appointments from 8am every morning. Urgent slots were available for patients who had an emergency. Information on the out-of-hours service was provided to patients online.

Patients were generally satisfied with the appointments system. They confirmed that they could normally see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients told us they could normally see the GP of their choice within three days. However, only 53% of patients reported they could see a preferred GP on the GP national survey. Some patients told us making an appointment was

Good

Are services responsive to people's needs?

(for example, to feedback?)

difficult due to the telephone system. They said they waited a long time on the phone and that sometimes the appointments for the same day were gone when they got through. This was particularly difficult for patients who worked as calling at 8am was difficult. The practice provided extended opening hours on Monday evenings which was useful to patients with work commitments. This was confirmed by patients. They also benefited from an online appointment booking system which allowed patients to make and cancel appointments online via the website.

The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. The practice had wide corridors for the use of patients with mobility scooters and wheelchairs. This made movement around the practice easier and helped to maintain patients' independence.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns. There was an individual member of staff responsible for dealing with complaints. We saw that information was available to help patients understand the complaints system on the practice website.

We looked at complaints received in the last twelve months and found these were dealt with in a timely manner and patients were responded to with an outcome of the investigation. The practice reviewed complaints periodically to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. Minutes of team meetings showing that complaints were discussed to ensure all staff were able to learn and contribute to any improvement action that might be required.

Are services well-led?

Requires improvement

(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 strategy document which was created in 2012. This document was based on a review of how the practice was performing and how demands had changed on the practice in recent years. The review led to a strategy for the coming years to meet the increasing demands on the practice. The practice manager told us the plan was formulated by meetings with a core staff group but that all staff had the opportunity to feed into the strategy. They said all staff reviewed the outcomes and were considered key in implementation. The strategy had assisted the practice to meet the changing demands to ensure patients could access and receive a safe and effective service. For example, changes to the appointment system were made.

Governance Arrangements

The practice had a number of procedures to guide staff and help manage the practice. We looked at safeguarding, recruitment and chaperone policies. They were accessible to staff. However, reception staff were not aware that they could access the safeguarding policies on the computer system. There was no whistleblowing policy to inform staff of their rights or how to report the poor conduct of colleagues or other healthcare professionals. The practice monitored some staff training and recruitment. However, there was no clear system to identify and manage all staff training requirements. For example, the practice had not identified information governance or equality and diversity training as a requirement for staff. Safeguarding training was not monitored to ensure staff training was undertaken at the required frequency.

The practice held monthly staff meetings at which governance issues were covered. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed staff meetings and action plans were produced to maintain or improve outcomes. Clinical team meetings were held every week to discuss changes in national guidance, audit outcomes or risks identified through significant events. However, there were no members of the nursing team represented at the meetings. Nurses were not fully involved in the clinical governance of the practice. The practice had completed a number of clinical audits, including audits of patient notes where actions were identified to improve note recording during home visits.

The practice had arrangements for identifying, recording and managing some risks. However, these were not always assessed and monitored to ensure this was undertaken to minimise risk. For example, there was no formal monitoring system for hygiene and infection control. There was no legionella risk assessment for the practice. The practice had not acted on the risk assessment Disclosure and Barring Checks (BDS). Some nurses did not have completed DBS checks despite being identified as requiring them. Portable appliance testing was not assessed and undertaken for all appliances. The practice manager showed us the practice health and safety assessment. There were risk assessments for fire and control of substances hazardous to health (COSHH).

Leadership, openness and transparency

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

We saw from minutes that team meetings were held regularly, at least monthly. 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. Staff were proud of the culture at the practice and all the staff we spoke with told us they felt valued. We also noted that team away days were held every year. However, nurses and administration staff were not represented at away days. This limited the input and learning outcomes at away days to GPs alone.

Practice seeks and acts on feedback from users, public and staff

The practice had disbanded its patient participation group (PPG) during early 2014. The partners and manager told us they were not satisfied with functioning of the PPG and believed it was not representative of the patient population. Therefore, they were working with patient representatives from the local CCG and using PPG models from other practices to create a more representative PPG.

Are services well-led?

Requires improvement

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

As a result the practice had not undertaken a patient survey in 2014. The practice partners and manager told us they discussed the feedback from the 2014 national GP survey and we saw they had a copy of the results available. The practice had not implemented any action as a result of the national survey. There was some feedback to suggest patients had some poor experiences making appointments due to the telephone system. There was also very positive feedback about the availability of appointments and the convenience in booking them at time which suited patients. The practice had a live survey which could be accessed through the website in order to gather patient views. We were shown complaints and comments from 2014 which the practice responded to and acted on.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Nurses and GPs told us that they felt confident in identifying specific training related to their roles or specialisms the practice enabled them to undertake this. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us they received appraisals and they had personal development plans which they were fully involved in developing. Staff told us that the practice was supportive of training and that they had protected training time to attend training. However, not all awareness and training was delivered to staff to enable them to perform their roles safely and appropriately. Some nurses and GPs did not have a full awareness of the Mental Capacity Act 2005, and there was no training delivered in equality and diversity or information governance.

The practice was a GP training practice. We spoke with a trainee GP who was told us they were well supported by the practice. They were given protected learning time which was never encroached on due to any of the demands on the practice, such as providing additional appointments for patients.

The practice had completed reviews of significant events and other incidents. These were shared with staff via meetings. For example, we saw one significant event where a prescription of antibiotics was issued without seeing or speaking to a patient. The prescription was cancelled and the incident was discussed in a staff meeting.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and Infection Control. The provider was not ensuring that service users, staff, and others who may be at risk were protected from the risk of healthcare associated infection because there was not effective operation of systems designed to detect, control and prevent the spread of such infection. Regulation 12(1)(a)(b)(c)(2)(a)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Requirements relating to workers. The provider did not take reasonable steps to ensure that employees were of good character, were physically and mentally fit to perform their roles, that staff were registered with their professional bodies and that information required under schedule 3 was available. Regulation 21 (a)(i)(iii)(b)(c)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting Workers. The provider did not ensure that staff were appropriately supported by receiving training to enable them to undertake their responsibilities safely and to an appropriate standard. Regulation 23 (1)(a)**