Dr R Hazeldine & Dr M Taylor

Quality Report

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

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Overall summary

Dr R Hazeldine & Dr M Taylor, Westcotes Health Centre, in Leicester, Leicestershire provide primary medical services to a mixed age population of approximately 5,723 patients.

As part of the planning of this inspection, we looked at the data provided by the local Clinical Commissioning Group (CCG) to help us identify if the service was safe, effective, caring, responsive and well-led.

The practice understood the local patient population and provided flexible and responsive services to meet their needs. The feedback we received from patients about the care and treatment at the practice was positive. Patients told us they found the service accessible and were involved in making decisions about, and consenting to, their care and treatment.

The staff we spoke with told us they were well supported by the GPs and practice manager and that they found them open and approachable. Staff had access to a whistleblowing policy and knew what to do if they needed to report concerns. We saw that there were systems in place to safeguard vulnerable adults and children from abuse.

The practice responded to the needs of older people; people with long-term conditions; mothers, babies, children and young people; the working age population; people in vulnerable circumstances and, people who were experiencing poor mental health.

The inspection found that the practice was in breach of the regulation relating to:

- Care and welfare of people who use services

- Records

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF, a national performance measurement tool) data, this relates to the most recent information available to the CQC at that time.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements are needed to ensure the service is safe.

There were quality monitoring systems in place, which helped staff to recognise and manage risk. However, patient safety alerts were deleted once they had been dealt with, so it was difficult to find out what action had been taken. The members of staff we spoke with knew that they were required to report any concerns they had, including errors and near misses. The practice had a system in place for reporting, recording and monitoring significant events. This enabled it to learn from patient safety incidents and identify the strengths and weaknesses in the care provided to patients.

The members of staff we spoke with could describe how their training in safeguarding had prepared them to recognise signs of abuse and situations where patients may be vulnerable.

The internal waiting room was in a different area to the reception desk, which meant that the reception staff could not see the patients waiting. They would therefore not be immediately aware of a medical emergency or violent incident.

The practice had arrangements to handle medicines safely, securely and appropriately. There were systems in place to control the spread of infections. This included annual testing for Legionella (a bacteria, usually found in water, which can cause illness).

Appropriate checks were carried out when staff were recruited to the practice. However, we did not see a recruitment policy or checklist.

Procedures were in place to deal with potential medical emergencies, although the practice did not have its own supply of oxygen. At the time of our inspection, we did not see a copy of the provider's business contingency plan (BCP), however a copy has been made available to the CQC since the inspection. A BCP is a document providing details of what contingency arrangements were to be actioned if there was an emergency at the practice.

The practice had arrangements in place to ensure that equipment was maintained and safe to use.

Are services effective?

The practice is effective.

The needs of the patients were assessed, and care and treatment was given in accordance with national guidelines.

Summary of findings

The practice had a system in place for completing clinical audit cycles. We saw a number of clinical audits had been completed.

There was a system to check ongoing professional registration for all clinical staff. Opportunities were available for staff to undertake professional development in addition to training required by the practice.

The practice worked with other healthcare services such as the midwifery, district nursing and community mental health teams in order to provide a coordinated and safe approach to patient care. There were a number of systems in place that enabled the practice to support patients with long term conditions. All new patients were offered a consultation, in which a health check was completed.

Are services caring?

The practice is caring.

A culture of openness and respect was promoted, in which patients were treated with dignity. Staff consistently spoke with patients in a friendly, kind, polite and helpful manner, and demonstrated an understanding of the need to maintain confidentiality at all times.

The GPs supported patients to understand their care and treatment options including the risks and benefits and providing information to enable them to be involved in making decisions. The feedback we received from patients suggested that they were routinely involved in decisions about, and consented to, their care and treatment.

Translation services, such as the use of language line and interpreters, were available to support patients whose first language was not English.

Are services responsive to people's needs?

Improvements should be made to ensure the practice is responsive.

The practice worked with the Clinical Commissioning Group (CCG) and other GP practices in the area to understand the needs of the local patient population and to organise services to meet those needs.

The practice was accessible. There were a number of ways in which a patient could make an appointment at the practice, including online, by telephone or in person. Home visits were available for patients who were not able to attend the surgery and telephone consultations were also offered where appropriate. Repeat prescriptions could be ordered online, by telephone or in person.

The practice had a system in place for handling complaints and concerns. However, there was no information displayed in the

Summary of findings

practice about how to raise a concern or make a complaint. The practice's complaints policy contained no information about where a patient could complain to if they remained dissatisfied with the response from the practice.

Are services well-led?

The practice is well-led.

The practice manager told us that they had a plan, though not written, to develop staff so they could seek promotion when an opportunity arose due to staff retirement or a vacancy. The practice team was small, but worked well, and there was evidence of the healthcare professionals working together well with their colleagues within the practice.

We saw the health and safety assessment for 2013, however there was no written record showing what actions had been taken as a result of this assessment. The practice had a range of policies and procedures in place to inform clinical practice. Regular audits against national standards were carried out as part of the clinical governance programme.

At the time of our inspection the practice did not have a Patient Participation Group (PPG) due to a general lack of interest by patients. However, we saw that the practice was in the process of setting up a new PPG. There was some evidence that feedback was obtained from patients. The practice had recently signed up to the Friends and Family Test (FFT).

There were sufficient training and development opportunities available, and members of staff had taken advantage of these opportunities.

Records were available that confirmed accidents and incidents were reviewed to identify any patterns or issues, and that appropriate actions were taken to minimise further occurrences. Staff we spoke with were aware of the incident reporting processes and they understood the requirement to report any concerns they had.

The Quality Outcomes Framework (QOF), a national performance measurement tool, was described by the practice as their means of ensuring and improving performance. The practice manager regularly met with the two GPs on a Friday and ensured that any actions that needed to be communicated were passed on to other relevant staff.

Summary of findings

The six population groups and what we found

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

Older people

The practice had appropriate arrangements in place to ensure the needs of older people were met. These arrangements included health checks for patients over the age of 65 years, the promotion of influenza immunisations and shingles vaccinations, and a scheme to minimise hospital admissions. Home visits would be made if the patient was unable to attend the practice. Care homes, which had patients registered with the practice, had a dedicated mobile telephone number with which to contact the practice which improved the communication. All new patients registering with the practice were asked to complete a questionnaire about alcohol consumption. Additionally, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the Health Centre.

People with long-term conditions

The practice had appropriate arrangements in place to ensure the needs of people with long term conditions were met. These arrangements included the monitoring of patients with long term conditions on a six monthly basis or more frequently if necessary, the promotion of influenza immunisations, monitoring for cardiac and respiratory illnesses, and monitoring of diabetes. Home visits would be made if the patient was unable to attend the practice. Advice was provided about healthy living options, as appropriate, to patients using the practice. All new patients registering with the practice were asked to complete a questionnaire about alcohol consumption. Additionally, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the Health Centre. The practice made referrals to the Fit for Work service.

Mothers, babies, children and young people

The practice had appropriate arrangements in place to ensure the needs of mothers, babies, children and young people were met. All nurses at the practice were trained in family planning. The practice worked with a health visitor and a midwife. Neonatal and six week baby checks were undertaken by the GP. Cervical screening was undertaken by all nurses working at the practice. All prescriptions of the contraceptive pill were reviewed annually or sooner if necessary**.** A local sexual health service was available. The practice made attempts to contact patients about their immunisations, including contacting teenagers who may be difficult to reach. All new patients registering with the practice were asked to complete a questionnaire

about alcohol consumption. Additionally, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the Health Centre. The practice made referrals to the Fit for Work service.

The working-age population and those recently retired

The practice had appropriate arrangements in place to ensure the needs of working age people (and those recently retired) were met. The practice had introduced the ability to book appointments online in addition to by telephone or in person. Online repeat prescription ordering had also been introduced. The practice was flexible in arranging appointment times for patients who may find it difficult to attend an appointment during working hours. Such arrangements included having a telephone consultation with the GP or nurse. NHS health checks were actively promoted. All new patients registering with the practice were asked to complete a questionnaire about alcohol consumption. Additionally, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the Health Centre. The practice made referrals to the Fit for Work service.

People in vulnerable circumstances who may have poor access to primary care

The practice had appropriate arrangements in place to ensure the needs of people in vulnerable circumstances who may have poor access to primary care were met. The practice ensured that health checks for patients with a learning disability were carried out. The practice liaised with a learning disability professional if there was a need to determine whether a patient had a learning disability. Influenza immunisations for patients were actively promoted. The practice had a good working relationship with the community dental service. The 'Language Line' translation service was used if the patient did not speak or understand English. A locally based interpreter service was also available and utilised when necessary. The practice offered disabled parking spaces and disabled access within the practice. All new patients registering with the practice were asked to complete a questionnaire about alcohol consumption. Additionally, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the Health Centre. The practice made referrals to the Fit for Work service.

People experiencing poor mental health

The practice had appropriate arrangements in place to ensure the needs of people experiencing poor mental health were met. There were two 'in-house' counsellors available from the Improving Access

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to Psychological Therapies (IAPT) service. Referrals were also made to a local NHS Trust's Open Mind team which provides recovery-focused talking therapies for patients who are stressed, depressed or have anxiety. All new patients registering with the practice were asked to complete a questionnaire about alcohol consumption. Additionally, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the Health Centre. The practice made referrals to the Fit for Work service.

Summary of findings

What people who use the service say

During our inspection we spoke with six patients. Each patient had positive comments about the practice. Patients told us that the practice was very nice and patient orientated, and they would recommend the practice to their friends, family members and colleagues. We received comments about the high standard of respectful and understanding communication from all the staff at the practice, and the availability of appointments. Patients told us that they were always treated as a 'partner' in their care and their consent was always obtained appropriately. We were told that, when necessary, referrals to other healthcare services such as specialists were done in a timely manner. The positive feedback was consistent from all of the patients we spoke with.

Prior to this inspection, we asked patients to complete the CQC 'Tell us about your care' comment cards to gather information on the experiences of patients using the practice. We supplied 51 comments cards, of which 50 were returned completed. 43 of the comment cards contained positive comments where the patients completing these cards repeatedly used words such as friendly, helpful, caring, professional, polite, genuine and efficient to describe the staff. These patients reported that they were listened to, and received, what they felt to be, excellent care and treatment, with respect and dignity. They also reported that they felt the environment was safe and hygienic. We saw comments about the ease in getting an appointment.

We received some negative comments. These included concerns about the opening hours of the surgery; the timeliness of referral to hospital; a medication change on a repeat prescription; and, a lack of information about ongoing care and treatment. We discussed these concerns with the practice manager.

Areas for improvement

Action the service MUST take to improve

The practice must ensure that it has oxygen readily available for use in emergencies.

Safety alerts, Legionella testing certificates, patient safety alerts and staff appraisals must be retained to provide a clear audit trail including, where appropriate, the outcomes and actions taken.

The key to the medical records filing cabinets must be securely stored.

Discussions between healthcare professionals must be documented.

Action the service SHOULD take to improve

The practice should ensure that reception staff are able to monitor the waiting area.

Working arrangements in relation to the palliative care gold standards framework should be strengthened.

The consent policy should be updated to include information about patients who lack mental capacity, or a separate policy relating to mental capacity should be developed.

There should be regular team meetings involving all members of staff working at the practice.

Reception staff should be trained in 'red flag words' to enable them to understand when a patient's description of their symptoms may require prompt medical advice and treatment. Red flag words are words that a patient may use when contacting the surgery to make an appointment. For example, a patient may report that they have a headache and a rash, which may indicate a serious medical condition.

Information about how to make a complaint should be displayed in the practice. The complaints policy should be updated to include information about what patients should do if they are dissatisfied with the practice's response to their initial complaint.

Dr R Hazeldine & Dr M Taylor

Detailed findings

Our inspection team

Our inspection team was led by:

Two CQC inspectors, a GP specialist adviser and a NHS practice manager specialist adviser.

Background to Dr R Hazeldine & Dr M Taylor

Dr R Hazeldine & Dr M Taylor provide primary medical services to a population of approximately 5,723 patients in Leicester City. A significant number of patients are aged between 25 to 34 years and are White British. The largest minority ethnic patient group served by the practice is Asian or Asian British. The services are commissioned by Leicester City Clinical Commissioning Group (CCG).

The practice is located within a health centre, which includes a second GP practice (not connected with Dr R Hazeldine & Dr M Taylor's practice), a dental surgery and a pharmacy.

Westcotes Health Centre is the main surgery.

The service is provided by two GP partners and three practice nurses, supported by a practice manager and reception and administration staff.

The opening hours are Monday, Tuesday, Wednesday and Friday 8.30am to 6pm, and Thursday 8.30am to 12 noon. The practice is closed at all other times and cover arrangements (an independent out-of-hours GP provider) were in place to ensure that patients could get medical advice and attention, if necessary.

Why we carried out this inspection

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

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before inspecting, we reviewed a range of information that we hold about the practice. We carried out an announced inspection on 11 July 2014. During our inspection we spoke with a range of staff including the practice manager, a GP, a

nurse, and all the reception and administrative staff. We spoke with six patients and received 50 completed CQC 'Tell us about your care' comment cards to gather information on the experiences of patients using the practice. We also contacted six local care homes and spoke with a range of external professionals who work alongside the practice to support patients' healthcare needs, to find out what their views of the practice were.

We observed how staff interacted with patients. We looked at the practice's policies, procedures and some audits.

We reviewed information that had been provided to us during the inspection and we requested additional information which we reviewed after the inspection.

Are services safe?

Our findings

Safe Track Record

Systems were in place to monitor the service and ensure patient safety was maintained at all times.

The members of staff we spoke with knew that they were required to report any concerns they had including errors and near misses. Near misses are events that could have resulted in injury or ill health.

The practice had an up-to-date policy for handling patient safety alerts such as those received from the Medicines and Healthcare Products Regulatory Agency (MHRA). We discussed patient safety alerts with the practice manager. We were told the alerts were received on the practice's computer system and shared with members of staff electronically. The practice manager confirmed that they acted on all safety alerts if relevant. However, once the action had been completed the safety alert was deleted from the system. The GPs and practice manager discussed the safety alerts in a weekly meeting.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording, monitoring, and learning from significant events. Records detailed how the staff team had responded when things had gone wrong by learning from their analysis of significant events. We saw the provider's up-to-date policy about significant events. This process, known as significant event analysis (SEA), enabled the practice to learn from patient safety incidents and identify the strengths and weaknesses in the care provided to patients. The practice manager kept information relating to the SEA processes. We reviewed a recent incident which had been classified as a SEA. There were comprehensive details about the incident, the actions taken, the outcome of the incident, and the actions taken to minimise the recurrence of the incident in the future. A check of the practice's accident book confirmed that the incident had also been appropriately recorded as an accident.

We saw that the SEA processes had been fully and comprehensively completed. Each member of staff had signed the SEA processes, which confirmed that the relevant information had been shared within the team. In addition to this we saw that regular meetings took place with the GPs and practice manager to discuss the SEAs.

Reliable safety systems and processes including safeguarding

The members of staff we spoke with were aware of their responsibilities in protecting patients. They could describe how their up-to-date training in safeguarding had prepared them to recognise signs of abuse and situations where patients may be vulnerable. They were also aware of their responsibilities to protect patients from abuse. We saw the practice's up-to-date policies relating to safeguarding. These provided staff with details about who to report any concerns about vulnerable adults and children to. Contact details of external organisations, including the local social services safeguarding team and the police, were included within the policies. A GP was the safeguarding lead within the practice.

We saw that appropriate checks were carried out when staff were recruited to the practice. People applying for a job submitted their curriculum vitae (CV) and, if shortlisted, were interviewed. If successful at the interview references were obtained. Checks of the person's identification, along with Disclosure and Barring Service (DBS) checks, were carried out. A DBS check, previously called a Criminal Records Bureau (CRB) check, identifies prospective employees who may have criminal convictions or be unsuitable for working with children or vulnerable adults. We saw that the immunisation status of a new member of staff was updated upon appointment to their new job.

Medical records were stored in lockable filing cabinets in a locked room. We were told these filing cabinets were locked when they were not in use. However, we saw that the keys to the filing cabinets were not stored securely, which meant that an unauthorised person could gain access to the filing cabinets if they found the key. We raised this with the practice manager at the time of our inspection and were informed that the security arrangements for the keys would be reviewed.

Monitoring Safety & Responding to Risk

At the entrance to the healthcare centre there was a large waiting area and the reception desk. Once patients registered at the reception desk they were asked to sit and wait in a separate internal waiting room in a different area to the reception desk. The reception staff were not able to see the patients in this internal waiting area and would not be immediately aware of a medical emergency or violent incident. This was a clear risk and one member of staff told us it was a big worry for them.

Are services safe?

The last health and safety inspection had taken place in April 2013 and was undertaken by the independent company managing the premises. Areas that had been identified as issues in the health and safety inspection had received attention. For example, a pull cord alarm had been installed in the accessible toilet in response to the recommendations from the health and safety inspection.

The practice had procedures in place to deal with potential medical emergencies. All staff had received training in basic life support and knew the whereabouts of the defibrillator, which appropriately trained staff were authorised to use. A defibrillator is a machine used to give an electric shock to a patient if their heart is beating in a seriously abnormal rhythm, in order to attempt to restore the normal heart rhythm.

The appropriate medicines for use in emergencies were kept in the practice and were within their expiry dates. Although the practice did not have its own supply of oxygen, we were told that, in an emergency, oxygen could be used from the dental surgery which was located in the same premises as the practice. However, we did not see any written protocol for this arrangement. We were also told that an ambulance station was close by, but this would not necessarily guarantee the response time of the ambulance. The practice had pulse oximeters which are small machines to check the level of oxygen in a patient's blood system. We saw the practice's up-to-date policy about the management of severe allergic reactions.

We spoke with two members of staff about the management of a medical emergency. Both staff were able to give a clear explanation as to what procedure they would follow in a medical emergency. For example, we were told that a GP would be interrupted if a patient was suffering from the signs of a heart attack in the reception. This assured us that staff members were appropriately trained and well informed about how to access prompt medical assessment and treatment in response to a medical emergency.

Medicines Management

The practice had arrangements to handle medicines safely, securely and appropriately. There were clear procedures in place for medicines management which included safe storage and prescribing of medicines. Patients had a choice of how to obtain their prescriptions and we saw how staff supported them in this process. Prescribing staff had access to clinical and prescribing guidance.

We saw the practice's up-to-date policy for repeat prescription medicines. The GPs checked all requests for repeat prescriptions and signed the prescription or invited the patient into the practice for an appointment if necessary for a review. We observed the reception staff handing completed repeat prescriptions to patients. They checked the identity of the patient, and checked whether either the prescription, or a medication management review, was due. The reception staff then either provided the prescription or offered an appointment. All repeat prescriptions were either stored at reception for collection or posted to the patient or a designated pharmacy for collection if there were pre-existing arrangements. Patients were advised to allow 48 hours for a repeat prescription request to be completed.

If a patient was taking warfarin (a blood thinning medicine), the blood clotting tests and warfarin prescribing were undertaken by another practice, located in the same building but not connected with Dr R Hazeldine & Dr M Taylor's practice. A system was in place to ensure that patients were followed up if they did not attend their appointment.

Two nurses working at the practice were trained as nurse prescribers. This meant they were able to prescribe some types of medicine and antibiotics for minor illnesses and injuries except in cases where the patient's blood pressure was raised. These patients were referred to the GPs for consultation and treatment. Both nurses had completed a nurse prescribing course and a minor illness course and this training was kept up to date.

The vaccine fridge was kept locked when not in use. The temperature of the fridge was checked and recorded daily when the practice was open. These recordings were within the acceptable fridge temperature range. We saw that all medicines stored in the fridge were within their expiry dates.

The GPs carried a range of medicines in their doctor's bag, which included medicine for infections, pain, allergic reactions and other emergencies. We were told that the medicine was re-ordered when the expiry date was approaching and we saw expiry dates being monitored during our inspection. The practice manager kept notes of the expiry dates and changed the medicines as necessary. We saw that all medicines were within their expiry dates.

Are services safe?

Cleanliness & Infection Control

The practice had systems in place to control the spread of infections. The practice was visibly clean and hygienic. We saw the toilets, including the accessible toilet near the waiting area, were visibly clean, and a notice was displayed about infection control and hand washing.

There was a named infection control lead with responsibility for ensuring that the policies and procedures for infection control, the safe handling and disposal of clinical waste and dealing with spillages were properly implemented and followed. The members of staff we spoke with told us protective clothing was provided, as part of their general uniform, and they knew about safe hand washing procedures. Sharps boxes in the consulting rooms were marked with the date when they were opened. There were clinical waste bins in the consulting rooms to dispose of dressings and other biological material.

We saw a cleaning audit had been completed in June 2014. The audit showed that all areas of the practice had been reviewed including the kitchen, accessible toilet, consulting rooms and entrance lobby. Action had been taken as a result of this audit. We saw that all areas of the practice were cleaned frequently and effectively according to a robust cleaning schedule.

The curtains in the consulting rooms, around the examination couches, were changed regularly, which reduced their infection risk.

We saw evidence that the independent company that manages the premises had tested for Legionella within the last year. This is in line with guidance from the Department of Health. Legionella is a bacteria usually found in water and can cause serious illness.

Staffing & Recruitment

The staffing establishments which included the skill mix (the levels, and type, of staffing at the practice) had not been reviewed for a number of years. There was no formal process to assess what the staffing and skill mix was.

The practice had a written contingency plan to address any shortfall in the staffing levels, such as if a GP or nurse was unable to work due to illness. In addition to this, the practice had an arrangement in place with a nearby GP surgery who would be able to assist if necessary. Staffing issues on a day-to-day basis were managed by the practice manager who liaised with the GP on duty to arrange cover. Any shortfalls in the GP staffing levels were addressed by using GP locums, but the practice manager told us that they could not recall a situation when this had happened. Any shortfalls in the nursing staffing levels were addressed by rearranging appointments or through an appointment with another nurse.

Dealing with Emergencies

At the time of our inspection, we did not see a copy of the provider's business contingency plan (BCP), however a copy has been made available to the CQC since the inspection. A BCP is a document which provides details of the contingency arrangements in the event of an emergency at the practice, such as utilities failure, fire or flooding. The practice confirmed that patient data can be accessed from the computer systems at the branch surgery, to ensure continuity of care in an emergency situation.

A fire drill was carried out last year by the independent management company. We saw that notes and comments about the outcome of the fire drill were emailed to all members of staff. There were no problems encountered during the fire drill. All staff were trained as fire marshals. We saw an up-to-date fire risk assessment for the premises. We saw that staff were aware of the procedures for evacuating the practice in a fire and that these were up to date and effective.

Equipment

The practice had arrangements in place to ensure equipment was maintained and safe to use. We saw that single use equipment was used and disposed of appropriately and in line with the manufacturer's guidelines.

The practice manager confirmed, and we saw evidence, that all equipment used in the practice (such as blood pressure machines) had been calibrated where necessary and checked recently. They also told us that portable appliance testing (PAT) of electrical equipment was scheduled to be carried out later in 2014.

We were told that the premises had an intruder alarm which was linked to a 24 hour monitoring system.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We found that the practice was working to best practice guidelines. We were told the GPs and nurses referred and worked to guidance from the National Institute for Health and Care Excellence (NICE). NICE gives independent evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health. This had been incorporated into the day-to-day clinical practice of the healthcare professionals.

We were told that the GPs regularly met to discuss the NICE guidance and prescribing guidance from the local Clinical Commissioning Group (CCG). CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of a local health care budget and 'buys' local healthcare services on behalf of a local population.

Management, monitoring and improving outcomes for people

The practice used clinical audits to monitor and improve services. Clinical audits are a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements. We saw a number of clinical audits, including audits relating to repeat prescriptions, prescribing of medicines for dementia, prescribing of non-steroidal anti-inflammatory drugs (NSAIDs), the use of aspirin in pregnancy, and the prescription of more expensive medications.

A regular review of medical records helped to identify patients who were eligible for periodic health and screening tests such as cervical screening. Systems were in place to remind patients to attend for tests when necessary. Processes were also in place to oversee patients who were at risk of being admitted to hospital, and those who needed treatment, medication reviews or scheduled vaccinations. This approach reduced the risks to patients with long term conditions by ensuring that they received regular health monitoring and reviews.

We spoke with senior members of staff from six local care homes and they all reported that the residents who were registered with Dr R Hazeldine & Dr M Taylor were highly satisfied with standards of care and the services provided. Overall, the response from all of the care homes was that they did not have any concerns about the practice. There were no problems accessing appointments and the GPs regularly visited their patients. They all thought the practice staff were helpful and considerate.

Effective Staffing, equipment and facilities

Each member of staff shadowed another member of staff before they worked independently. This was confirmed by the evidence in the two recruitment files we saw. The practice manager told us that they had a three year programme in place whereby all staff were rechecked by the DBS. We saw that all staff had a current DBS check. A DBS check, previously called a Criminal Records Bureau (CRB) check, identifies whether prospective employees have criminal convictions or are unsuitable for working with children or vulnerable adults.

The practice manager had a system to check ongoing professional registration for all clinical staff. A list of all clinical staff showed their current registration status and the date that the registration should be renewed.

There were opportunities for staff to undertake professional development in addition to training required by the practice. The practice manager identified ongoing training needs of the staff through the annual appraisal process. The annual appraisal process is an opportunity for the member of staff to discuss the previous years' performance, achievements and training, and plan for the forthcoming year, with a senior member of staff. The practice manager and the clinical staff were appraised by a GP while all other staff were appraised by the practice manager. The practice manager told us that these were last completed in March 2013 and were due again now. We did not see any records of the 2013 appraisals as the manager told us that these had been destroyed by accident. However, one nurse we spoke with confirmed that they indeed had an appraisal in March 2013 with the GP and had made agreements to attend professional development in a number of areas including chronic obstructive pulmonary disease (COPD) and alcohol management.

There was an effective training schedule that promoted effective staff competencies. We saw a record of training undertaken by staff in 2013 and this included training in chronic obstructive pulmonary disease (COPD), dementia, immunisation, infection control, suicide awareness,

Are services effective?

(for example, treatment is effective)

chaperone training, safeguarding and asthma update. The practice manager told us that there was a similar programme for 2014 and we saw evidence of this part completed programme.

The practice manager explained that, due to the small size of the practice team, there were no formal arrangements in place for supervision or clinical supervision (regular one-to-one meetings between each member of staff and their manager where they can discuss any issues and offer support). However, staff told us they felt supported. The practice manager regularly met with the two GPs on a Friday and any actions that needed to be communicated to other relevant staff were either communicated directly by the practice manager or through a diary note on the computer through SystmOne. The members of staff we spoke with confirmed this arrangement.

The manager told us that they would refer any professional performance issues to the relevant professional regulator, either the General Medical Council (GMC) for doctors or the Nursing and Midwifery Council (NMC) for nurses. The manager could not recall dealing with a performance issue but would manage any performance issues of non-clinical staff through one-to-one meetings and supervision. We did not see any evidence that supported this process.

Working with other services

The practice worked with other healthcare services such as the midwifery, district nursing and community mental health teams in order to provide a coordinated and safe approach to patient care. We spoke with a number of professionals working within these healthcare services. We received positive feedback about the practice being run well, having good communication and the GPs being accessible. When necessary, information was appropriately shared between teams about patients with complex needs or where there were concerns about their health and wellbeing. We were told that there were a number of informal meetings and discussions, though not of all the content of such meetings was documented.

The practice received messages from out-of-hours services, and accident and emergency departments to share information about patients who had accessed these services. This helped to ensure that the practice could provide follow-up care and treatment, if necessary.

Health Promotion & Prevention

We spoke with a practice nurse about the systems the practice used to help patients with long-term conditions. These included a register of patients with chronic illness, and a system to recall patients with diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD) at least every six months. In addition, there were personal care plans for this patient population so unplanned hospital admissions are minimised. The personal care plan involved a named doctor being responsible for the care of these patients and coordinating any care that was required. We were told that this was a recent development and had yet to be evaluated.

The practice worked with the palliative care gold standards framework, but the details of this work were vague. The practice nurse told us that they contributed to the work of other agencies, such as the palliative care nurses and out-of-hours service, but not directly in the delivery of the gold standards framework. We did not see any documentary evidence of this at the time of our inspection.

We saw a range of information displayed in the reception and waiting areas, which included information about infection control, diabetic foot care, NHS health checks, vitamin D, breastfeeding, upset tummy, 'ambulances are for emergencies', and podiatry (foot care).

We saw arrangements in place for the annual influenza vaccination programme. This included printing reminders on repeat prescriptions. Influenza vaccinations were actively promoted from the beginning of September onwards. In early November the practice began to identify patients who were eligible for the influenza vaccination though had not as yet had the vaccination. These patients were contacted by the practice to arrange an appointment. We also saw systems in place for the children's vaccination programme.

There were no reported issues about women obtaining a suitable appointment for a cervical smear. We were told that appointments for cervical smears were available with the nurse. There was some flexibility in the appointment times to avoid patients experiencing difficulties in attending this important appointment.

All new patients were offered a consultation, in which a health check was completed.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The practice promoted a culture of openness and respect. We spoke with six patients all of whom had positive comments to make about their experience of the practice. They found the practice to be friendly, helpful, and they felt they received good medical attention from their GP and from the practice nurses.

We observed that the members of staff in reception knew how to treat patients with dignity and respect. We heard and observed members of staff consistently greeting patients in a polite and helpful way. Throughout our inspection, we heard staff speaking with patients in a friendly, kind and respectful manner. They addressed patients using their preferred name and sought their permission before discussing private personal information with them or other members of the practice team.

The reception was open plan making it difficult for staff to fully protect patient confidentiality. Patients confirmed that the layout of the reception area meant it was not a confidential space. However, private rooms were available near to the reception area should a patient wish to discuss a confidential matter with the receptionist. We saw that consultations and examinations, with either the GPs or the nurses, took place in private. Computer screens which showed confidential patient data faced inwards so that this sensitive information could not be seen by patients arriving at the surgery. When we spoke with members of staff, they demonstrated a good understanding of the need to maintain confidentiality at all times.

We observed reception staff informing patients who were waiting to see the nurse being told that the nurses was running late. We also observed a member of staff declining to register a new patient. This was due to the fact that the patient lived outside the practice's catchment area. The patient was appropriately and helpfully signposted to practices that did cover the area in which they lived.

At the time of our inspection the practice did not have a female GP, though we were told that this was rarely an issue as there was always a female nurse on duty. The practice had an up to date chaperone policy. The policy included information for staff to follow in the event that a patient required a chaperone during their consultation with the GP or other healthcare professional.

Regular meetings occurred between the GPs and the practice nurses about end of life care. We were informed that these meetings did not include the district nurses or Mcmillan nurses, however these professionals were contacted by telephone. Patients who were known to be at the end of their life had their appointments expedited (which meant they would be seen by the GP much quicker, as opposed to booking a routine appointment).

Involvement in decisions and consent

The GPs supported patients to understand their care and treatment options including the risks and benefits and providing information to enable them to be involved in making decisions.

The feedback we received from patients suggested that they were routinely involved in decisions about, and consented to, their care and treatment. Patients said the GP discussed the care and treatment options available to them. Patients said their views were listened to and taken into account before a decision was made about their treatment. They told us they spent enough time with their GP to ask questions and they had confidence in the ability of the GP plan their care effectively. Patients told us that their GP consultations were thorough. They reported that the GP listened to them and they were consulted about their treatment options. We saw a selection of leaflets providing information about different medical conditions and treatment options were available for patients.

Patients told us they had a choice about which GP they could see and about where their assessments and treatment could take place if this was being provided by other healthcare services.

There were arrangements in place to share information with other services such as the out of hours service about the decisions made in relation to end of life care. This included decisions about resuscitation.

We found that translation services were available to support patients whose first language was not English. Such services included the use of language line and interpreters. In addition to this, we were told that a family member of a patient had recently acted as the interpreter. The information we saw displayed, and available for patients, in the practice was written in the English language. We did not see any information in other languages.

Are services caring?

We were sent a copy of the practice's up to date consent policy. This provided details of the various types of consent and how consent should be obtained. The policy also described, and we discussed with a GP, the 'Gillick Competence'. The Gillick Competence refers to a whether a child under the age of 16 has sufficient understanding and intelligence to enable them to understand fully what is proposed and, if this is the case, give consent for themselves. The policy did not provide any information or guidance about what process should be followed if an adult lacked mental capacity (the ability to make decisions for themselves). However, the policy did contain a resource list including, amongst other resources, latest Department of Health guidance about consent to treatment which does provide information about adults who lack capacity.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the Clinical Commissioning Group (CCG) and other GP practices in the area to understand the needs of the local patient population and to organise services to meet those needs. CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of a local health care budget and 'buys' local healthcare services on behalf of a local population. The practice had information available about their local population including age, levels of deprivation and the prevalence of disease. This helped them to work collectively to plan services to meet patient's needs.

Referrals to other health care providers were made by the GPs via standardised forms.

The practice was located within a health centre, which included a second GP practice (not connected with Dr R Hazeldine & Dr M Taylor's practice), a dental surgery and a pharmacy. Dr R Hazeldine & Dr M Taylor's practice was located on the ground floor. There was level access into the main building, though the main door was not automatic. Reception staff would open the door for the patient if they were unable to open it for themselves. We did however note that the doors to the pharmacy, which lead into a separate entrance into the building, and into the large waiting area, were both automatic. There was a loop system (a type of communication aid) in place to support patients with hearing loss.

Access to the service

We found that the practice was accessible. There were a number of ways in which a patient could make an appointment at the practice. These included online, via the internet, by telephone or in person. Pre-bookable and 'on the day' appointments were available every week day. All of the patients we spoke with said it was easy to get an appointment with their chosen doctor and they could access a same day appointment in urgent circumstances if they needed to. If appropriate, the practice nurse could see the patient, for example, in the case of a chest or throat infection, or insect bites. The practice nurse was able to prescribe antibiotics and antihistamines, having undertaken the necessary recognised training.

Home visits were available for patients who were not able to attend the surgery and telephone consultations were also offered where appropriate. Reception staff dealt with patients promptly and during our inspection, at peak times, two to three patients were waiting to see the GP. We were told waiting times in the practice, in general, were satisfactory to see the GP, though waiting times to see the nurse could be longer.

The practice had its own website which provided some useful information about their opening times and the services they provided and advised patients what to do in the event of an emergency situation. Information was also provided as to what telephone number to contact if the practice was closed. The practice hours were Monday, Tuesday, Wednesday and Friday 8.30am to 6pm, and Thursday 8.30am to 12noon. The practice was closed at all other times and cover arrangements were in place to ensure that patients could seek medical advice if necessary.

Repeat prescriptions could be ordered online, via the internet, by telephone or in person. Patients we spoke with told us the system for repeat prescriptions worked well and they received their prescriptions in a timely manner. Patients were told that the time was 48 hours for a repeat prescription request to be completed.

There was reserved parking for patients with a disability.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns.

We did not see any information displayed within the practice about how to make a complaint. However, the practice brochure provided some information about the complaints procedure. We were sent a copy of the practice's up to date complaints procedure. This contained information about acknowledging, in writing, the complaint within two working days of receipt and a reply to the patient being made within ten working days, or the patient should be provided with an update and an estimate timescale. The procedure included details that the patient could also make a complaint to the local Clinical Commissioning Group (CCG). However, the procedure did not include any details about where a patient could complain to if they remained dissatisfied with the response from the practice, for example, NHS England, and the Parliamentary and Health Service Ombudsman.

Are services responsive to people's needs?

(for example, to feedback?)

We were shown the latest complaint that had been received in February 2013. We saw how the GP had responded in writing to the complaint. The information, which included the lessons learnt, from the complaint had been shared with all staff. Staff had signed to confirm that they had received and read this information. We saw clinical meetings had taken placed in June 2013, September 2013 and January 2014. The clinical meetings included discussions about any complaints that had been made, and the lessons learnt from the complaints.

Are services well-led?

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

Our findings

Leadership & Culture

The practice manager told us that they had a plan to develop staff so they could seek promotion when an opportunity arose due to staff retirement or a vacancy. We however did not see evidence of any written strategies for leadership development or succession planning. The practice lead for governance and clinical governance was one of the GPs who was on annual leave at the time of our inspection. The practice manager told us that priorities for leadership and team objectives would be determined by the Quality Outcomes Framework (QOF), a national performance measurement tool. The GPs would meet with the practice manager around November of each year to review their performance and agree priorities for meeting any shortfalls. A member of staff we spoke with confirmed this arrangement.

The practice team was small but worked well. On the day of our inspection we saw that the practice manager spent time with the reception staff, and regularly communicated with the clinical staff ensuring services were being delivered effectively. There were no meetings that encompassed the whole practice team. The practice manager met with the GPs on Fridays, and there were regular clinical meetings that involved the clinical staff only. The practice manager was very visible and supportive to all staff. This was done through regular interaction with staff and the use of the diary note on SystmOne. Three members of staff told us that the working arrangements were open transparent and that they felt supported at all times by the GPs and the practice manager.

There was evidence of interdisciplinary working. For example, nursing staff assessed and treated minor illnesses. They had direct access to the GP if they encountered a condition that they assessed as needing a GP's advice and treatment. During our inspection we saw that this system worked well, with the nurse calling on the GP when required.

The practice did not have a policy on equality, diversity and human rights. The practice manager told us that every staff understood the importance of equality diversity and human rights, and they acted accordingly.

Governance Arrangements

The practice manager had an overview of the day to day workings of the practice. They had worked at the practice for a number of years and had a wealth of knowledge about the systems and processes operating to ensure the practice ran smoothly. However, we found that not all of this knowledge had been translated into policies and procedures. Therefore, should the practice manager be away from the practice for a prolonged period of time, staff may not be aware of specific systems and processes.

Practice issues with the whole team were usually discussed informally and these discussions were not recorded. We were told that the practice manager was supportive and approachable, and issues were usually dealt with as they arose. However, we were told that team meetings did not take place. Records were kept of regular clinical meetings (between the GPs and the practice manager) to discuss practice issues and agree the most appropriate course of action to take.

The practice discussed the information from safety alerts at management meetings, though there was no means of accounting for decisions made or actions taken because they could not be accounted for or attributed back to the original alert. This is a significant gap in the safety audit trail and is an area where the practice must make improvements.

We saw peer review audits of a GP had been completed in June 2014, by another GP. This included comments about the face to face communication, areas well done, areas requiring improvement, and a developmental plan to improve, where necessary, the quality of the care provided.

We saw the practice had a range of policies and procedures in place to inform clinical practice. Certain members of staff had been identified as leads for various areas of practice, such as infection control and safeguarding. Members of staff told us that they were able to seek guidance from other colleagues to support them if they were unsure of a matter or required assistance.

Systems to monitor and improve quality & improvement (leadership)

Regular audits against national standards were carried out as part of the clinical governance programme to help the practice manager and the clinical team evaluate services and improve quality where necessary. The audits which had been undertaken included repeat prescriptions,

Are services well-led?

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

prescribing of medication for dementia, prescribing of non-steroidal anti-inflammatory drugs (NSAID), the use of aspirin in pregnancy, the prescription of more expensive medications, health and safety, and cleaning.

Patient Experience & Involvement

We were informed that the practice had previously had a Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who have an interest in the services provided. The aim of the PPG is to represent patients' views and to work in partnership with the practice. The PPG had gradually phased out, due to a general lack of interest by patients. Therefore, at the time of our inspection, the practice did not have a PPG. However, we saw that the practice was in the process of setting up a new PPG.

The results of the 2012/13 Patient Experience Survey indicated that the practice performed higher than other practices in the CCG area. For example, 89% of respondents were satisfied with the overall experience of the GP surgery, compared to 80% in the CCG area. We also saw that 97% of respondents were satisfied with the helpfulness of the receptionist, compared to 83% in the CCG area and 88% nationally.

Prior to this inspection, we asked patients to complete the CQC 'Tell us about your care' comment cards to gather information on the experiences of patients who used the practice. We supplied 51 comments cards, of which 50 were returned completed. 43 of the comment cards contained positive comments and the patients completing these cards repeatedly used words such as friendly, helpful, caring, professional, polite, genuine and efficient to describe the staff. These patients reported that they were listened to, and received excellent care and treatment, with respect and dignity, within a safe and hygienic environment. We saw comments about the ease in getting an appointment. Seven comments cards contained some negative comments. These included concerns about the opening hours of the surgery; the timeliness of referral to hospital; a medication change on a repeat prescription without prior consultation with the patient; and, a lack of information about ongoing care and treatment.

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

The practice had not consulted with patients through a patient satisfaction survey recently. We did however see the results of the patient questionnaire for 2012/13 which revealed the majority of comments from patients were positive. We noted that patients had commented positively about the GP, with 100% saying they were confident in the GP and 100% saying they would be happy to see the GP again.

The practice had recently placed a suggestion box in the reception area, though this had yet to be used by patients.

We were informed, and saw on the practice's internet website, that the practice had signed up to the Friends and Family Test (FFT), ahead of the need to do so by 01 December 2014. The FFT is an important feedback tool for patients who use NHS services to have the opportunity to provide feedback on their experience.

Staff knew about the whistleblowing procedures and told us they were encouraged and supported to report risks and things that had gone wrong. We saw the practice's up to date whistleblowing policy. This policy provided staff with information about how and where they could raise concerns, both within the practice and to external organisations.

Management lead through learning & improvement

The members of staff we spoke with told us that they worked well together as a team. We saw evidence of this throughout our inspection. We were told by staff that there were sufficient training and development opportunities available, and members of staff had taken advantage of these opportunities. The records we saw showed us that the staff received ongoing training and development. The practice manager was clear about how poor performance of staff would be managed although they told us this had never been an issue as the staff were loyal and dedicated, and had worked in the practice for a number of years.

We saw records that confirmed accidents and incidents were reviewed to identify any patterns or issues, and that appropriate actions were taken to minimise further occurrences. Minutes of clinical meetings showed that learning from incidents took place.

Identification & Management of Risk

The practice monitored quality and safety issues and these were discussed at clinical meetings. All of the staff we spoke with were aware of the incident reporting processes and they understood the requirement to report any concerns they had.

Are services well-led?

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

The QOF, a national performance measurement tool, was described as the means of ensuring and improving performance. The GPs would meet with the practice manager around November of each year to review their performance and agree priorities for meeting any shortfalls. Their current priority was to review and address preventable (unplanned) admissions to hospitals.

The practice manager regularly met with the two GPs on a Friday and any actions that needed to be communicated to other relevant staff on performance or improvements were either communicated directly by the practice manager or through a diary note on the computer SystmOne. The members of staff we spoke with confirmed this arrangement.

There was evidence that the clinical team worked together to ensure a high quality service. A practice nurse told us that they regularly audited their practice against agreed standards and reviewed their practice. We saw evidence of an audit that checked prescribing practices of controlled drugs. As a result improvement was made so these drugs were prescribed in a safer way. The practice had re-audited their practice again to make sure improvements had been sustained.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had appropriate arrangements in place to ensure the needs of older people were met.

People over the age of 65 years old were offered health checks, carried out by the nursing staff, on annual basis. These health checks were undertaken in the practice, however arrangements were made for home visits if the patient was unable to attend the practice. Both influenza immunisations and shingles vaccinations were actively promoted and administered by the nursing staff. Home visits would be made if the patient was unable to attend the practice.

We were informed that a scheme was in place to minimise the risk of a hospital admission. Care plans were in place including, where appropriate, 'do not attempt resuscitation' instructions.

Care homes, which had patients registered at the practice, had a dedicated mobile telephone number with which to contact the practice which improved the communication. When we spoke with senior members of staff from six local care homes they all reported that the residents who were registered with Dr R Hazeldine & Dr M Taylor were highly satisfied with standards of care and the services provided. Whilst some minor issues were reported to us, overall the response from all of the care homes was that they did not have any concerns about the practice. There were no problems accessing appointments and the GPs regularly visited their patients. They all thought the practice staff were helpful and considerate.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice had appropriate arrangements in place to ensure the needs of people with long term conditions were met.

Patients who were diagnosed with long terms conditions, such as diabetes, chronic obstructive pulmonary disorder and mental health problems, were monitored on a six monthly basis. However, this monitoring was personalised to the needs of the patient, which meant that the monitoring would take place more frequently if necessary.

Influenza immunisations were actively promoted and administered by the nursing staff. Home visits would be made if the patient was unable to attend the practice.

Cases of atrial fibrillation (AF, a heart condition that causes an irregular and often abnormally fast heart rate) were detected in this population group by checking the patient's pulse during a consultation. Spirometry (the measuring of breath) was used to detect cases of chronic obstructive pulmonary disease (COPD).

Patients with obesity or who had a family history of diabetes were encouraged to have regular glucose monitoring to detect the onset of diabetes. Nurses provided advice about healthy living options, as appropriate.

All new patients registering with the practice were asked to complete an Audit-C questionnaire. This questionnaire asks questions about the patient's alcohol consumption. In addition to this, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the health centre. NHS health checks were actively promoted.

The practice made referrals to the Fit for Work service. This service provided one to one, impartial support and advice to help patients, either employed or self-employed, who were signed off sick from work to get back to work.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice had appropriate arrangements in place to ensure the needs of mothers, babies, children and young people were met.

All nurses at the practice were trained in family planning. The practice had direct telephone contact with a Health Visitor, who regularly visited the practice. A midwife was based within the practice. Neonatal and six week baby checks were undertaken by the GP.

Cervical screening was undertaken by all nurses working at the practice. All prescriptions of the contraceptive pill were reviewed annually or sooner if necessary. Long-acting reversible contraception (LARC) was promoted in line with government guidance.

A local sexual health service was available and this service was promoted by the nurses, where appropriate. Screening for chlamydia was also promoted by the nurses.

Young patients under the age of 16 years old were seen alone by a doctor or nurse if they requested to be. The doctor or nurse assessed their competency to find out if the patient had sufficient understanding and intelligence to enable them to understand fully what was proposed and, if this was the case, gave consent for themselves. Information sharing with parents, in line with confidentiality, was dependent on the outcome of the competency assessment.

The practice made attempts to contact patients about their immunisations. This included contacting teenagers who may be difficult to reach.

All new patients registering with the practice were asked to complete an Audit-C questionnaire. This questionnaire asks questions about the patient's alcohol consumption. In addition to this, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the health centre. NHS health checks were actively promoted.

The practice made referrals to the Fit for Work service. This service provided one to one, impartial support and advice to help patients, either employed or self-employed, who were signed off sick from work to get back to work.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice had appropriate arrangements in place to ensure the needs of working age people (and those recently retired) were met.

The practice had introduced the ability to book appointments online, via the internet, in addition to by telephone or in person. Online repeat prescription ordering had also been introduced, which made ordering repeat prescriptions easier. The practice was flexible in arranging appointment times for patients who struggled to attend an appointment during working hours. Such arrangements included having a telephone consultation with the GP or nurse.

All new patients registering with the practice were asked to complete an Audit-C questionnaire. This questionnaire asks questions about the patient's alcohol consumption. In addition to this, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the health centre. NHS health checks were actively promoted.

The practice made referrals to the Fit for Work service. This service provided one to one, impartial support and advice to help patients, either employed or self-employed, who were signed off sick from work to get back to work.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice had appropriate arrangements in place to ensure the needs of people in vulnerable circumstances who may have poor access to primary care were met.

The practice ensured that the health checks for patients with learning disabilities were carried out. At the time of our inspection, it was confirmed that 100% of these checks had been completed. The practice liaised with a learning disability professional if there was a need to determine whether a patient had a learning disability.

Immunisations for patients within this population group were actively promoted by the practice. This included immunisations for influenza.

The community dental service was based in the health centre, and the practice had a good working relationship with this service.

The language line translation service was used if the patient did not speak or understand English. A locally based interpreter service was also available and utilised, when necessary.

The practice offered reserved disabled parking spaces and disabled access within the practice.

All new patients registering with the practice were asked to complete an Audit-C questionnaire. This questionnaire asks questions about the patient's alcohol consumption. In addition to this, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the health centre. NHS health checks were actively promoted.

The practice made referrals to the Fit for Work service. This service provided one to one, impartial support and advice to help patients, either employed or self-employed, who were signed off sick from work to get back to work.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice had appropriate arrangements in place to ensure the needs of people experiencing poor mental health were met.

There were two 'in-house' counsellors available from the Improving Access to Psychological Therapies (IAPT) service. This service is an NHS service which provided support to patients suffering with depression, anxiety and related problems.

The practice made referrals to the Fit for Work service. This service provided one to one, impartial support and advice to help patients, either employed or self-employed, who were signed off sick from work to get back to work.

Referrals were also made to a local NHS Trust's Open Mind team which provided recovery-focused talking therapies for patients who are stressed, depressed or have anxiety.

All new patients registering with the practice were asked to complete an Audit-C questionnaire. This questionnaire asks questions about the patient's alcohol consumption. Patients were referred to the drug and alcohol service, as necessary. In addition to this, new patients were also asked to provide details about their smoking status. A smoking cessation counselling service was available in the health centre.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The practice did not have oxygen in place for dealing with emergencies which are reasonably expected to arise from time to time.** **Regulation 9(2).**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Safety alerts, Legionella testing certificates, patient safety alerts and staff appraisals were not always retained to provide a clear audit trail including, where appropriate, the outcomes and actions taken.** **Discussions, between healthcare professionals, were not always documented.** **The key to the medical records filing cabinets was not securely stored.** **Regulations 20(1)(b)(ii) and 20(2)(a).**