The Sandhurst Group Practice

Quality Report

The Sandhurst Group Practice

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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?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of The Sandhurst Group practice on 2 October 2014. During the inspection our team visited both the Owlsmoor and Sandhurst practice's because both are registered with the CQC.

The practice is rated as requires improvement across both practice sites. We found evidence of weaknesses in the operation of safety systems and improvements must be made. Systems to manage medicines, appropriately vet staff before they commence work and systems to reduce the risk of cross infection were not operated consistently. The practice must take urgent action to improve these aspects of the service. Although many aspects of the practice were good, improvement in both safety and leadership are required.

Our key findings were as follows:

- the practice is involved in promoting health. It holds an award for smoking cessation.
- patient feedback overall was very positive. Particularly in the areas of being treated with kindness and compassion and being involved in decisions about care and treatment.
- a range of appointment options are available and additional appointments are made available at times of high demand.
- the practice works closely with a very active patient focus group and acts on patient feedback.

We saw an area of outstanding practice:

- arrangements were made with local commissioners to provide ear nose and throat, urology and ophthalmic clinics at the practice. Therefore, the need for patients to attend hospital outpatient clinics was reduced.

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

Importantly, the provider must:

Summary of findings

- ensure medicines are stored securely and a system is in place to check expiry dates of stored medicines.
- act to improve standards of cleanliness and follow guidance to reduce the risk of cross infection.
- carry out a risk assessment to determine the requirement for reception and administration staff to undergo criminal records checks.
- carry out criminal records checks for practice nursing staff.
- ensure all pre-employment checks are completed and recorded.
- ensure there are recorded quality and monitoring processes and procedures to identify, assess and manage risks to the safety and welfare of patients and others
- risk assess portable electrical appliances and undertake appropriate safety checks based on findings.

In addition the provider should:

- consider, with commissioners and local community groups, how a consistent and accessible translation service for patients whose first language is not English can be offered.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Patients were at risk of harm because systems and processes had weaknesses. Not all recruitment checks had been carried out to ensure staff were of good character, out of date medicines were held in medicines fridges and not all control of infection guidance had been followed to reduce the risk of cross infection. GPs and management reviewed significant events and learning from these was shared. Staff knew how to report a concern. Emergency medical equipment and medicines were available and staff knew how to deal with a medical emergency. Appropriate training, expertise and procedures were evident to support safeguarding of children and vulnerable adults. This had increased staff awareness of their roles and responsibilities in this area.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements could be made. Reference to national and local guidelines was inconsistent. Data showed patient outcomes were at or above average for the local area. National institute for health and care excellence **(**NICE) guidance was referenced and was held on the practice computer system Patient's needs were assessed and care planned and delivered in line with current legislation. This included promotion of good health. Staff had received training appropriate to their roles and further training needs were identified through the annual appraisal system. Multi-disciplinary working was evidenced and a range of additional services were provided at the practice including a urology clinic. Recording of induction training could not be evidenced and maintenance of training records was inconsistent.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice highly in most aspects of care. The majority of patients said they were treated with compassion, dignity and respect. They told us they were involved in care and treatment decisions and when appropriate in planning future care. Information was provided to help patients understand the care available to them. We observed staff treated patients with kindness and respect. Patients told us that staff were helpful. We saw staff maintained patients' confidentiality and privacy.

Summary of findings

Are services responsive to people's needs?

Good 

The practice is rated as good for responsive. The practice engaged with the local clinical commissioning group (CCG) to support service improvements identified in the local area plan. There are a wide range of appointment opportunities offered, including evening and weekends. However, patients did not always report easy access to appointments. The practice kept the appointment system under review and worked with their patient focus group to find ways of promoting better understanding of the appointment system. Patients with multiple care needs and those over 75 have a named GP to support continuity of care. The practice had appropriate facilities and was well equipped to treat patients and meet their needs. An accessible complaints system was in place with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for well led. Some policies and procedures were not specific to the operation of the practice and quality monitoring processes were not operated consistently. The means to identify, assess and manage risks for the safety and welfare of patients were not always operated reliably. The practice did not have a clear vision or strategy. Staff reported an open management culture and told us they could communicate with both the GPs and management on any issue. The staff meeting structure supported sharing of information and learning. The practice actively sought feedback from patients and staff. Feedback was acted upon, for example the way flu immunisation clinics were delivered was altered to reflect feedback. The practice had an active patient focus group which contributed to the decision making processes of the practice.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for provision of services to older people. All patients over the age of 75 have a named GP. Immunisation campaigns for this group of patients were undertaken and the practice compared well with others for delivering these. Clinics to support the needs of older patients are held at the practice to avoid the need for travel to hospital. For example urology, ear nose and throat (ENT) and audiology. Systems for monitoring and improving safety across the practice were not operated consistently and not all risks were managed via appropriate check and control processes. This had an effect on the services provided to most population groups.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the population group of people with long term conditions.

The practice managed care and support for this group of patients in line with current guidelines for good practice. Staff were trained to support these patients and provided disease specific clinics. For example diabetes and chronic obstructive pulmonary disease (COPD) (COPD is severe shortness of breath) clinics. The results from the most recent Quality and Outcomes Framework (QOF) showed good performance in managing patients with long term conditions. Systems for monitoring and improving safety across the practice were not operated consistently and not all risks were managed via appropriate check and control processes. This had an effect on the services provided to most population groups.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. A full range of child health services were available at the practice. Mother and baby health checks were carried out and the practice performance in delivering childhood immunisations was above the local CCG average. The practice held a clinic at a local secondary school providing a wide range of confidential advice for young patients including sexual health advice. Systems for monitoring and improving safety across the practice were not operated consistently and not all risks were managed via appropriate check and control processes. This had an effect on the services provided to most population groups.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people. The practice offered Saturday morning and one evening a week surgeries for those who found it difficult to attend during the working day. Smoking cessation clinics were held and the practice held an award for this service. A full range of family planning advice and support was available. A travel clinic was available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people living in vulnerable circumstances. The practice recognised and supported the needs of patients in vulnerable groups. Patients from the traveling community are registered with the practice and a network had been established to support those patients who found difficulty with reading and writing. The practice invited all patients with a learning disability to have an annual health check-up. Seventy nine per cent of these patients received a health check in the last year. Named GPs were responsible for the care and treatment of patients with a learning disability who live in supported accommodation. The provision of translation support to patients whose first language is not English was inconsistent.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the population group of patients experiencing poor mental health. The practice made provision for the care and treatment of patients experiencing poor mental health. The practice supported their patient focus group with an education event which included spotting the early signs of dementia. A visiting talking therapy service was available which offered both individual and group support. Patients with long term mental health problems had individual care plans and a specialist mental health worker was invited to attend the practice multi professional meetings.Systems for monitoring and improving safety across the practice were not operated consistently and not all risks were managed via appropriate check and control processes. This had an effect on the services provided to most population groups.

Summary of findings

What people who use the service say

We reviewed the results of the national patient survey from 2013 which contained the views of 129 patients of the practice. We also looked at the summary of results and action plan from the practice patient focus group survey from last year. This incorporated the views of 1776 patients. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. However, the results for accessing convenient appointments and the practice opening times were below the national average. The practice was considering how to address these issues and the practice survey would focus on this in 2014.

We spoke with 16 patients on the day of inspection and reviewed 14 comment cards completed by patients in the two weeks before the inspection. Both the patients we spoke with and the comments we reviewed were generally positive and often described excellent care. There were a small number of negative comments regarding access to appointments and we relayed these to the registered manager and deputy practice manager.

Areas for improvement

Action the service MUST take to improve

- ensure medicines are stored securely and a system is in place to check expiry dates of stored medicines.
- act to improve standards of cleanliness and follow guidance to reduce the risk of cross infection.
- carry out a risk assessment to determine the requirement for reception and administration staff to undergo criminal records checks.
- carry out criminal records checks for practice nursing staff.
- ensure all pre-employment checks are completed and recorded.
- ensure there are recorded quality and monitoring processes and procedures to identify, assess and manage risks to the safety and welfare of patients and others
- risk assess portable electrical appliances and undertake appropriate safety checks based on findings.

Action the service SHOULD take to improve

- consider, with commissioners and local community groups, how a consistent and accessible translation service for patients whose first language is not English can be offered.

Outstanding practice

- arrangements were made with local commissioners to provide ear nose and throat, urology and ophthalmic clinics at the practice. Therefore, the need for patients to attend hospital outpatient clinics was reduced.

The Sandhurst Group 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, two practice manager specialist advisors, a second CQC inspector and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to The Sandhurst Group Practice

The Sandhurst Group Practice offers primary medical services via a general medical services (GMS) contract to the population of Sandhurst, Owlsmoor and surrounding areas. Nearly 20,000 patients are registered with the practice. The patients are split between the two practice sites. The practice delivers services to a slightly higher number of patients with long term conditions than the local average. There is a significant population of people originating from Nepal in the area and many of these are registered patients of the practice.

Care and treatment is delivered by eleven GP partners. There are seven male GP partners and four female partners. The practice employs two salaried GPs (one male and one female), five practice nurses, a health practitioner and three healthcare assistants. GPs and nurses are supported by the practice manager and a team of reception and administration staff. The practice had not been subject to a previous inspection.

A new practice manager came into post in late August 2014. Prior to this the practice had been without a manager for some months. The GPs at the practice acknowledged that some systems and management processes requiring monitoring and review had not been addressed during the interim period.

The practice takes an active role within the Bracknell and Ascot Clinical Commissioning Group (CCG). One of the GPs is a medical director on the CCG board and the practice manager is also a member of the board. The practice is accredited to support doctors in training.

Services are provided from:

Sandhurst Surgery, 72 Yorktown Road, Sandhurst, Berkshire, GU47 9BT

and

Owlsmoor Surgery, 1 Cambridge Road, Owlsmoor, Sandhurst, Berkshire, GU47 0UB

Both practices were visited during the inspection.

The practice had opted out of providing Out Of Hours services to their patients. Some of the GPs also worked for the local provider of Out Of Hours services. There were arrangements in place for patients to access care from an Out Of Hours provider.

Detailed findings

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 the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Bracknell and Ascot Clinical Commissioning Group (CCG). We carried out an announced visit on 2 October 2014. During our visit we spoke with a range of staff, including GPs, practice nurses, the deputy practice manager, health care assistants (HCAs) and administration staff.

We observed how patients were being cared for and talked with 16 patients and reviewed personal care or treatment records. We reviewed 14 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

The practice had fewer patients in older age groups than the national average and a higher number of patients of working age. The number of patients recognised as suffering deprivation was lower than the local and national average. The number of patients with long term medical conditions was slightly higher than the CCG average. A significant number of Nepalese patients were registered with the practice.

Inadequate

Are services safe?

Our findings

Safe Track Record

The practice had a system in place to circulate alerts from national bodies such as the Medicines and Healthcare products Regulatory Agency (MHRA). Information relating to withdrawal or a dose change for specific medicines was passed to the GPs for action. We were told by the GPs we spoke with that patients affected were contacted and the necessary changes made in consultation. However, we did not find evidence of the action being co-ordinated or completed. There was no system to return a report of completed action to the practice manager.

When there was an alert related to medical equipment it was passed to either the senior nurse or dealt with by the practice manager. There was no central record of the actions taken.

Any incidents that could have affected the safe treatment and care of patients were recorded as significant events.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed the record of significant events from the last eighteen months. A slot for significant events was on the weekly practice meeting agenda and a dedicated meeting occurred annually to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff via their line managers. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt able to do so.

Reliable safety systems and processes including safeguarding

We spoke with six GPs during our visit. All of them told us they were trained to level 3 in safeguarding children. However, we were unable to corroborate this as the practice did not hold records of GP training completed. The registered manager told us GP partners were up-to-date with their appraisals which would include verification of their safeguarding training. The practice nurses we spoke with told us they had taken appropriate safeguarding training. They told us how they would respond to a suspicion of abuse and they all knew where to locate the practice safeguarding policies and the details of the local safeguarding authority.

We spoke with nine members of the administration and reception staff. Five at Sandhurst and four at Owlsmoor. There was a mixed level of understanding among administration and reception staff of the forms of abuse they might encounter during the course of their duties. Staff told us if they had concerns relating to individual patients they would inform their manager or the lead GP responsible for safeguarding. There was evidence that staff had received basic training in safeguarding and they were able to tell us where they would find the practice policies and the details of the local safeguarding authority.

The practice had a chaperone policy. The availability of a chaperone service was prominently displayed at both Sandhurst and Owlsmoor locations. Practice nurses and health care assistants acted as chaperones. The nurses and health care assistants we spoke with told us they had been trained to carry out this role and described how they would carry out chaperone duties. None of the practice nurses or health care assistants had been subject to criminal records checks. Chaperone duties were undertaken by staff that had not been subject to appropriate checks to ensure they were of good character to carry out the role. Some patients we spoke with said they were offered the service of a chaperone when a physical examination was required during their consultation.

Medicines Management

We checked medicines stored in the treatment rooms and fridges. We found two out of date medicines from a sample check of over 20 were stored in one of the fridges at Sandhurst. The medicines were held for the visiting midwives. We also found two out of date medicines belonging to the practice at the Owlsmoor location. There was a risk that out of date medicines could have been issued to patients. The rest of the medicines we saw were stored in accordance with manufacturers' instructions. There was a policy for maintenance of the cold chain and this included action to take in the event of a potential failure. However, three of the four medicine fridges in use could not be locked and were in rooms that could be accessed by patients and others. There was a risk that medicines could be removed without staff knowing.

Inadequate

Are services safe?

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location. The small quantity of Controlled Drugs kept on site was held securely. The Standard Operating Procedure for Controlled Drugs showed they were handled in line with legal requirements.

We saw a record of the practice meeting with the clinical commissioning group (CCG) medicines management pharmacist. There was an action plan which GPs were following to further improve prescribing. When nurses or health care assistants (HCAs) administered prescription only medicines e.g. vaccines, Patient Group Directives (PGD's or Patients Specific Directions (PSD's) were in place in line with relevant legislation. PGD's and PSD's give specific guidance on the administration of medicines and include authorisation for nurses and HCA's to administer them.

The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance. This covered how changes to patients' repeat medicines were managed and the system for reviewing repeat medicines to ensure they were still safe and necessary. Patients we spoke with who received repeat medicines confirmed that they received an annual review of their medicines. Not all prescriptions were subject to a robust receipt and issue process. Prescriptions with GP and practice details already printed on them were kept in a locked room but were not booked in to the practice and were not accounted for when given to the individual GP. There was a risk that if a prescription pad went missing this would not be noticed.

Cleanliness & Infection Control

The practice had a lead for infection control. We could not evidence that this member of staff had undertaken training in infection control to enable them to provide advice on the practice infection control policy and carry out staff training. The infection control policy we were shown was not adapted to the specific processes carried out at the practice. For example, the policy stated all staff would receive infection control training. When we asked staff about infection control training we found that this had been limited to occasional refresher training for GPs and practice nurses. There was no evidence of reception and administrative staff receiving induction training about infection control specific to their role or receiving any training on this topic. We observed that reception staff at the Sandhurst Surgery received specimens from patients over the main reception desk. The staff offered a bag to patients to place the specimen container in but disposable gloves were not available to staff when carrying out this process. Staff were placed at risk by receiving specimens in this manner.

The practice had not carried out an annual infection control audit as required by guidance contained in the relevant code of practice. There was no action plan that identified any improvements in infection control processes and procedures. Clinical waste was not stored safely and presented potential risk to staff. We found a sharps box in a consultation room at the Sandhurst location that was filled to the point where a needle was level with the lid of the box presenting a danger. We also found a sharps box containing used medicines which should not have been mixed with sharps. The cupboards at both sites holding bags of clinical waste and full sharps boxes were not safe. When we opened the door to the cupboard at Owlsmoor Surgery full bags of waste fell out. This posed a risk of infection or injury to staff and patients.

The premises were not wholly clean and tidy. We were told there were cleaning schedules for both sites. The schedule for Owlsmoor could not be located. There was no evidence of the cleaning staff recording that they had completed the tasks on the schedule at Sandhurst and no formal monitoring to ensure cleaning standards were maintained. The cleaning schedule did not include deep cleaning of the chairs in the waiting rooms. These chairs were covered in a permeable soft fabric. We found three chairs in the Sandhurst waiting room that were stained and a chair in a consulting room with a split in the fabric. There were no plans to repair or deep clean these chairs.

There were records confirming GPs and nurses had completed their course of immunisation for Hepatitis B. There was no risk assessment for reception and administration staff to inform whether they needed immunisation for Hepatitis B. The practice did not have a policy requiring Locums to demonstrate if they were up-to-date with control of infection processes and procedures.

The practice had not undertaken a legionella risk assessment or carried out water testing at either Sandhurst or Owlsmoor practices. The risk of contracting infection from waterborne bacteria had not been evaluated.

Inadequate

Are services safe?

Equipment

Records showed essential maintenance was carried out on the main systems within the two practice sites. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions. A recent check of the emergency lighting had identified three emergency lights were not working. Repair to these lights was not organised until we pointed the report out to the deputy practice manager. Calibration of medical equipment was carried out in line with manufacturers' instructions. There were records detailing these checks. Portable electrical equipment had last been tested in 2011. Arrangements had not been made for re-testing and a risk assessment on which items required testing and at what frequency had not been undertaken. The practice could not be assured that all electrical equipment was safe to use.

Staffing & Recruitment

There was a documented recruitment and selection policy. This policy was not implemented consistently. We saw a copy of a risk assessment tool that could be used to decide whether a member of staff required a criminal records disclosure and barring service (DBS) check. There was no evidence that this had been used.

Practice nurses and health care assistants told us they had not been subject to a criminal records check and we found no evidence of the checks being undertaken in the personnel files we reviewed for these staff. There was no risk assessment in place to inform which members of reception and administration staff required a criminal records check and which staff did not. The practice had not ensured all staff were free of a criminal record.

We looked at seven personnel files. None of the files reviewed contained all of the recruitment checks required by regulation. For example, the files for the two salaried GPs did not contain any references or photographic identification. Another file only contained proof of identity and a contract for the member of staff. There was no application form and no proof of professional registration at the time the member of staff started working. The practice did not require staff to complete a health questionnaire as part of the recruitment process. However, staff we spoke with told us they were asked about their health during their interview. The practice had not obtained all evidence to confirm staff were of good character and fit to carry out their roles.

We spoke with a locum GP on their first day at work in the practice. They told us they had not supplied a copy of their criminal records check or proof that they were registered as a practitioner with a relevant authority prior to their commencing work at the practice. This was confirmed by the deputy practice manager. We also found that the GMC registration for this GP had not been verified. Appropriate checks on the locum GP had not been undertaken to ensure they were fit and legally registered to offer care and treatment to patients.

Monitoring Safety & Responding to Risk

The practice operation of systems to monitor and respond to risk was inconsistent. Maintenance of the building, essential safety equipment and calibration of medical equipment was undertaken on a scheduled basis. For example, fire fighting equipment and the fire alarm systems were maintained in accordance with legislation and manufacturer's instructions. However, monitoring of medicines and the standards of cleanliness were not carried out.

Minutes of meetings we reviewed showed the GPs and management reviewed significant events, clinical audits and complaints and learning from these was shared across the practice. There were no records of other risks being discussed. GPs and management were not aware that out of date medicines were held in medicine fridges or that the storage facilities for clinical waste were not sufficiently large to hold all waste safely.

Arrangements to deal with emergencies and major incidents

We saw records that all staff had received training in basic life support annually. The training for 2014 was booked to take place in the week after our inspection. All staff asked including receptionists and administration staff knew the location of the Automated External Defibrillator (AED), oxygen, pulse oximeter, emergency drugs and nebuliser.

The practice had business continuity plans in place for both Sandhurst and Owlsmoor practice's. These included measures to maintain the service or keep patients informed when incidents affected the ability to maintain services from the practice sites. For example, if there was a flood affecting one of the practices.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with demonstrated various methods to access guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We could not evidence a consistent approach in accessing clinical guidelines. The patient record system in use contained templates in which NICE guidelines were embedded. Whilst there was no formal policy for ensuring GPs and nurses remain up-to-date, all the GPs interviewed were aware of their professional responsibilities to maintain their knowledge. Some guidance was held in a shared file on the practice computer system. This was accessible to both GPs and nurses.

GPs and nurses were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. It used the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The practice used QOF to assess performance and undertook clinical audit. The last QOF data available to Care Quality Commission (CQC) showed the practice performs well in comparison to other local practices. For example, in the care of patients with diabetes.

The practice had a system in place for completing some clinical audit cycles. For example an audit of one specific medicine used in the treatment of diabetes. This audit resulted in updating the medicines used for this condition and was repeated to ensure the changes in prescription had been completed. Other audits completed included fitting of coils, dermatology referrals and specific medicines used in the treatment of rheumatism.

GPs at the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. An audit on outcomes of minor surgery had been undertaken. This showed surgical procedures had been undertaken appropriately.

Effective staffing

Staff who had been appointed in the last year told us about their induction programmes. An induction checklist was used to support this process. Staff were required to attain competency in a range of relevant tasks before the checklist was signed off. The checklists were held in training files awaiting completion of probationary periods. We were told that staff felt well supported when they first started working at the practice and that a formal review of their progress was held at the end of their first three months in post. There was evidence that these meetings were held.

Training and professional development was in place. We saw that essential training was available to reception and administration staff. The training completed by staff at the Owlsmoor surgery was recorded. A similar record was not available at Sandhurst surgery. The staff we spoke with told us that when they identified training needs the training was made available. Nursing staff held records of the training and development they completed to maintain their professional registration. We saw that all nurse professional registrations were up-to-date. The nurses employed were legally registered to practice.

Staff of all disciplines received annual appraisal. The 2014/15 appraisals had been deferred due to the change in practice management. Staff were aware that their appraisal would be held early in 2015. There was a record of previous appraisals in the staff files we reviewed. GPs were actively involved in professional revalidation and received their regular appraisals.

There were systems in place to disseminate relevant learning through a structure of team meetings. For example, updates in clinical treatments and protocols were shared with the nursing team on a monthly basis. We saw minutes of the various team meetings. GPs and nurses took part in the quarterly review of significant events. The minutes of the meetings included the learning points and these were made available to all staff.

Working with colleagues and other services

We found the practice worked with other service providers to meet patients' needs and manage complex cases.

Requires improvement

Are services effective?

(for example, treatment is effective)

Blood results and X ray results from hospital departments and communication from the Out Of Hours provider were received electronically and sorted for the relevant GP to review. The GPs reviewed results and ensured any action arising was communicated to the patient within 24 hours of receipt. There was a system for GPs to review results for absent colleagues. Letters from A&E, outpatients and discharge summaries were received by courier mail. The GPs we spoke with told us alternative means such as fax were used to communicate urgent information requiring prompt follow up with the patient. All outpatient and discharge letters were reviewed in less than 3 days from receipt. Patients told us GPs were able to support them after they attended hospital appointments. The practice had a policy for communicating with the Out Of Hours service via a system of special notes.

Referrals were made using the Choose and Book service. There was evidence of the practice referral process. Patients told us they knew why they were being referred and confirmed referrals were made promptly. We heard how the practice supported patients who found it difficult to use the choose and book system. We were given an example of the support given to a patient who was experiencing a mental health problem. The patient gave consent for a member of practice staff to process the referral on their behalf.

The practice hosted specialist clinics. These included urology and ENT (ear nose and throat) clinics. Hearing tests were available on site. These clinics assisted patients by preventing them from having to travel to the main hospital. Elderly patients found these services convenient.

The practice held multidisciplinary team meetings every six weeks to discuss the needs of patients with complex needs and those requiring end of life care and treatment. Notes of these meetings showed that district nurses and palliative care nurses attended. Actions required to support patients were noted. For example, the level of support required from the palliative care nurses.

Information Sharing

Midwives attended the practice and worked closely with GPs to support the needs of expectant mothers. There was liaison with the local community mental health team to support the needs of patients with mental health problems. A named mental health worker was available to the practice. We saw minutes of meetings related to supporting the needs of patients receiving end of life care. These showed that relevant professionals were involved.

Consent to care and treatment

GPs we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA). They knew when it may be required to assess a patient's capacity to make a decision and how a decision can be made in a patient's best interests. GPs demonstrated a clear understanding of the Gillick competencies (guidance on gaining consent from patients under 16).

We saw the practice had consent forms for patients to consent to specific procedures in the practice including minor surgery. Records confirmed that written consent was obtained for minor surgical procedures.

Health Promotion & Prevention

One of the GPs at the practice was a member of the clinical commissioning group (CCG) board and was involved in drawing up the local health promotion plan (known as the Joint Strategic Needs Assessment). GPs we spoke with were aware of the CCG commissioning aims.

The practice did not offer health checks to all new patients registering with the practice. However, the health care assistants had received training to undertake these checks from November 2014.

All patients with a learning disability were offered a physical health check and 79% received the check up in the last 12 months. Records showed us that 14% had refused consent to the check-up. Increasing the number of smoking 'quitters' was high on the local health agenda. The practice had not identified the smoking status of all patients over the age of 16 but had a specialist advisor smoking cessation clinic every week. We saw that the practice had won an award for achievement in the last year for supporting a significant number of patients to stop smoking.

We noted that information was available to support national screening programmes for cervical smears, mammography (breast screening), chlamydia screening (a sexually transmitted disease) and bowel screening. The practice achievement for cervical screening was 2% above the national target. This was better than the CCG average. We saw a clear process to follow up patients who did not attend for cervical smears.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice offers a full range of immunisations for children. The local commissioning plan includes increasing the take up of childhood immunisations to above 90%. The practice had exceeded this target over the last year. Flu vaccination was offered to all patients over the age of 65, those in at risk groups and pregnant women. Shingles vaccination was offered to older patients in line with national guidance

Human Papilloma Virus (HPV) vaccination was offered to teenage girls. The practice held a clinic at the local secondary school offering a wide range of advice appropriate to the needs of younger patients. Sexual health advice was available at this clinic. The practice also offered a travel vaccination service.

The practice website contained a page entitled 'Family Health. This included sections specific to the needs of different patient populations registered. For example, there was a section dedicated to child health for six to fifteen year olds and another section on sexual health.

The patient focus group had worked with the GPs to run a patient education evening. This covered many topics including how patients could spot early signs of dementia and the importance of maintaining fluid intake for older patients. There was an evaluation from the patients who attended this event which was very positive.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent patient satisfaction data available for the practice. This included information from the national patient survey completed in 2013 to which 129 patients responded and a survey of 1776 patients undertaken by the practice's Patient Focus Group. The evidence from both these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 108 of the 129 respondents rated the practice good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs with a score of 96%. Ninety per cent of practice respondents rated the GP good at listening to them and 87% saying the GP gave them enough time.

Some of the older patients we spoke with told us the GPs made special effort to give them time to explain their concerns and they were very sympathetic and supportive of their needs.

Patients completed Care Quality Commission (CQC) comment cards in the two weeks before our inspection to provide us with feedback on the practice. We received 14 completed cards and the vast majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful and caring. They said staff treated them with dignity and respect. Only two comments were less positive and the comments related to the appointment system. We also spoke with 16 patients on the day of our inspection. Most of the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We discussed a less positive comment relating to availability of translation services with the registered manager.

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.

The reception areas at both Sandhurst and Owlsmoor were of open design and did not allow much space near the reception desks. Some patients we spoke with and 33% of patients who responded to the national survey were concerned their conversation with reception staff could be overheard by others. The practice had taken some measures to address this issue. For example, music was played into the waiting room to reduce the chance of patients in this area overhearing what was being discussed at the reception desk. We observed that the receptionist was able to call for assistance from colleagues when a queue of patients developed at the reception desk.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Most calls from patients were taken in offices set behind the reception desk. The office at Sandhurst was partly separated from the reception by a solid wall. Staff taking calls from patients in this office were mindful of the need to avoid repeating a patient's name or clinical information and to speak quietly when on the telephone.

Care planning and involvement in decisions about care and treatment

Eighty per cent of patients who completed the last national patient survey said GPs were good at involving them in decisions about their care. Sixty eight per cent of patients reported the same about nurses. This was above the local average. The national survey also reported 88% of patients were satisfied with the explanation of test results. Patients we spoke with on the day of our inspection told us they felt involved in decisions about their care and treatment. They also told us they felt listened to and supported by staff.

Some of the patients we spoke with had long term medical conditions. They confirmed that they had been involved in planning their care and treatment and understood the importance of regular reviews of their condition.

Patients experiencing long term poor mental health had care plans in place which they had been involved in developing in discussion with their usual GP. There was a system in place to call this group of patients in for their physical health checks.

Good

Are services caring?

The practice was working with patients who had been identified with a risk of developing long term health problems. GPs told us how they had developed care plans with this group of patients and involved the patients in devising their plan.

Patient/carer support to cope emotionally with care and treatment

The practice hosted counselling and talking therapy services for their patients. We were told how this service had been promoted at a recent health education event organised by the patient focus group.

Eighty two per cent of patients who completed the national survey said GPs treated them with care and concern. This result compared favourably with other practices locally. We spoke with some parents of young children. They told us the GPs and nurses were very caring towards their children and involved the child, when possible, in discussions about their care and treatment.

The practice had a carers' register and provided some leaflets with information for carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

Services were responsive to patients' needs. A variety of clinics and visiting services were available including audiology and ophthalmology. The needs of the younger population were served for example, by the provision of family planning and sexual health advice. The practice had a larger number of younger patients and patients of working age compared to the other practices in the area.

The practice offered home visits to housebound patients who required them if requested before 11am. Access to emergency home visits was available throughout the day. This provided older patients, mothers with young children, carers or patients in vulnerable circumstances an opportunity to see a GP when they had difficulty visiting the practice.

Longer appointments were available for patients if required, such as those with long term conditions. 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.

Support groups and external services were advertised on the website, such as the 'Help Spot' for young patients who attended Sandhurst School. Help Spot offered a service dedicated to young patients health and staff from the practice attended the service to provide advice and treatment. The website also contained a section where patients could find a variety of local services including those provided by the independent health sector. The practice hosted 'Talking Therapies' provided by a local mental health support service provider. Physiotherapy services were available on site.

The practice had made special efforts to inform the travelling community when an outbreak of measles had occurred in the area. They ensured that the message was passed to members of this community who had difficulty reading and writing by using the community network.

The practice had patient registers including learning disability and palliative care registers. There were regular internal as well as multidisciplinary meetings to discuss patients' needs. The practice worked collaboratively with other care providers such as local care homes, health visitors and district nurses.

Immunisation rates for flu vaccinations for older people compared well with other practices in the clinical commissioning group (CCG) area and childhood immunisation rates were consistently above the 90% national target.

There was an online repeat prescription service for patients. This enabled patients who worked full time to access their prescriptions easily. Patients could also drop in repeat prescription forms to the surgery to get their medicines. Patients told us the repeat prescription service generally 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 an open registration policy for all residents of the local area. There was a local traveller community and patients from this group registered at the practice. The GPs visited local nursing homes to provide care and support to residents. Both Owlsmoor and Sandhurst were accessible to patients in wheelchairs or with mobility problems. There was space in the waiting rooms for patients to sit in either a wheelchair or mobility scooter. All consultation and treatment rooms were located on the ground floor. Written information could be produced in large print for patients with visual impairment. Neither practice had an induction loop system to amplify voice for patients with hearing impairment.

The practice had a significant number of patients whose first language was not English registered. We were told that provision of translation services for some members of this group was difficult. We observed patients from this community bringing relatives and other members of the community to translate for them.

Access to the service

A range of appointments was available. This included routine appointments bookable in advance, on the day appointments and telephone consultations. The practice was open from 8am to 6.30pm from Monday to Friday. An evening surgery was held every Thursday between 6.30pm and 7.30pm. A Saturday morning surgery alternated between the Sandhurst and Owlsmoor sites and was available between 8.30am and 11am.

The practice had a system in place to respond to patient demand. When the appointments for either the morning or afternoon had been filled patients requiring advice and

Good

Are services responsive to people's needs?

(for example, to feedback?)

treatment were offered telephone consultations. Extra appointments were added to ensure patients wanting to be seen 'on the day' were catered for. Staff told us that they always made provision for patients to receive medical advice and support by offering an appointment to see a GP or nurse. Assessment of medical need for an appointment was not undertaken by administration and reception staff. Patients were either offered a face-to-face appointment or a telephone consultation to enable a GP to decide whether an appointment was required.

We saw that the mix of appointments types was adjusted to meet expected peaks in demand. For example, there were more telephone slots and on the day appointments available on a Monday morning. There was recognition that more staff were needed in the morning to receive phone calls from patients wishing to book appointments. We saw that there were more staff on duty in the morning than in the afternoon.

Some patients we spoke with were not aware of the availability of these 'extended hours' surgeries. The results of the national patient survey showed that only 70% of patients were happy with the practice opening hours and 91% said they received a convenient appointment. These results were lower than the national average. The range of appointments available was extensive but patients were not always happy with this availability. Members of the patient focus group told us this issue would be included in the 2014 practice survey.

Listening and learning from concerns & complaints

The practice had a policy for dealing with complaints and concerns. This was displayed in the waiting room and appeared on the website. The policy was in line with recognised guidance and contractual obligations for GPs in England.

Evidence seen from reviewing a range of feedback about the practice, including complaint information and supporting operational policies for complaints and whistleblowing, showed that the practice responded quickly to issues raised. The summary of complaints received in 2014 showed that all had been dealt with in accordance with the practice policy. Some complaints triggered the practice's significant event process. All were discussed in practice meetings to identify any learning outcomes and share these with staff. There was a designated person responsible for dealing with complaints.

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 used a set of guiding principles to underpin service delivery. The principles were displayed on staff notice boards and on an electronic file which all staff could access from the practice computer system. These principles included maximising the continuity of care for patients and delivering a high standard of care to benefit the health of patients. The practice aimed to deliver the best quality of care in a timely manner and this was evident from our discussions with GPs and staff. There was evidence that the practice placed dignity and respect for patients at the top of their agenda. Close working with the patient focus group was evident and service development reflected the views gathered by this group.

Governance Arrangements

Meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. Significant events were shared with the practice team to ensure they learnt from them and received advice on how to avoid similar incidents in the future. GPs led on specific areas of clinical management. However, not all of the staff we spoke with were aware of which GP was responsible for which area. Staff told us that they felt confident either the practice manager or the senior nurse would ensure issues they raised were passed on to the GPs and that information would be fed back from the GPs. There was a nominated Caldicott Guardian (a person responsible for ensuring safe keeping and appropriate use of information). There was an information governance policy in place and we saw that the practice had quality assured the processes in operation for use and storage of patient data.

Leadership, openness and transparency

Staff told us they felt management and the GPs operated in an open way. Staff felt able to talk with any of the GPs and said their line managers were always available to support them. We found the senior nurse had responsibility for a wide range of management responsibilities whilst carrying a full clinical caseload. Staff were clear on their responsibilities and roles within their teams. There were delegated responsibilities within the management team.

The practice manager was responsible for human resource policies and procedures and maintenance of appropriate employment records. We reviewed a number of policies, for example the recruitment and induction policy which were in place to support staff. We were shown the staff handbooks for both sites that were available to all staff, this included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. We also reviewed staff personnel files and other records relating to staff. We found the information contained in these records was inconsistent. Some important information relating to staff was not held. For example, risk assessments for the requirement of criminal records check. There was a central record of completed staff training at Owlsmoor but not at Sandhurst. There were no records of partners' registration status or training.

The practice manager was also responsible for the health and safety policies, and quality monitoring for the practice. We found the health and safety policy statement was generic and not specific to the practice. The fire risk assessment was last undertaken in 2007. Staff we spoke with told us a fire evacuation drill had not been carried out for at least two years. We found the standards of cleanliness within the practice were not subject to a formal monitoring process. A control of infection audit had not been completed in accordance with current national guidance. Many policies and procedures relevant to the management of the practice had not been subject to regular review. The processes used to identify, assess and manage risk were not operated consistently.

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

There was an active patient focus group that had been in existence since 2009. The members of this group told us that they found the practice very responsive to patient views and the feedback they obtained from patients. We saw the practice took action on feedback from the group. For example, patients were able to call to book appointments from 8am when before the last survey telephone lines did not open until 8:30am.

Staff told us and notes of meetings we reviewed showed that they were able to give feedback on issues that concerned them. We saw an example of the practice nurses suggesting a change in how flu clinics were organised. The suggested change had been implemented to provide walk in flu clinics.

Are services well-led?

Requires improvement

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

Management lead through learning & improvement

GPs were active in the process of revalidation and this was supported by audits carried out either individually or as a practice. Clinical updates were shared at the regular practice meetings. A training record for the staff at Owlsmoor was in place and some certificates of training were held in staff files. However, staff told us of training they had completed that had not been recorded in their records. Nurses held their training records. A record of the nurse's professional registration was held. This proved nurses were legally registered to carry out their role. Staff received annual appraisals and these were recorded in their staff files.

The practice was a GP training practice and completed self-assessments to confirm their ongoing suitability to support doctors in training.

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 The registered person had failed to ensure as far is reasonably practicable that (1) – (a) service users; (b) persons employed for the purpose of carrying on the regulated activities; and (c) other who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activities are protected against identifiable risks of acquiring such and infection by the means of (2) (a) the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infection; and (c) the maintenance of appropriate standards of cleanliness and hygiene in relation to – (i) premises occupied for the purpose of carrying on the regulated activities; and Regulation 12 (1) (a), (b), (c) and (2) (a) and (c) and (i).

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 The registered person had failed to – (a) Operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person – (i) is of good character and

This section is primarily information for the provider

Compliance actions

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

Regulation 21 (a) (i) and (b).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Management of medicines. The registered person had not protected users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activities. Regulation 13.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers (1)The registered person had failed to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to - (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activities against the requirements set out in this Part of these regulations; and; (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activities.

This section is primarily information for the provider

Compliance actions

(2) For the purpose of paragraph (1) the registered person must –

(b) have regard to –

(iii) the information referred to in regulation 20 (Records)

Regulation 10 (1) (a) and (b) and (2) (b), (iii).