

North Camp Surgery

Quality Report

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of North Camp Surgery, 2 Queens Road, Farnborough, Hampshire, GU14 6DH on 11 May 2015. Overall this practice is rated as requires improvement. This practice was inspected at this time following concerns raised by NHS England. The practice had been required by NHS England to not carry out any immunisations until the outcome of an investigation.

Specifically, we found the practice to be good for providing, effective, caring and responsive services. It also required improvement for providing services to older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe services and well led.

- Patients were complimentary about the care and support they received from staff. The practice had responded to the needs of an increasing Nepalese population group by employing a Nepalese speaking receptionist. Two of the GPs could also speak Nepalese.
- Staff told us they were committed to providing a service that put patients first.
- The practice worked with other health and social care professionals and organisations to ensure that their patients received the most effective support and treatment. However at the time of our inspection the practice had been required to stop immunisation of patients by NHS England.
- Staff were trained in and aware of their responsibilities for safeguarding of vulnerable adults and children. There were systems and processes in place to raise concerns and there was a culture of reporting and learning from incidents within the practice.

Summary of findings

- Patients told us they could always get an emergency appointment and waiting time for routine appointments was satisfactory.
- The GP partners and salaried GP said they were committed to working to keep a high level of patient service as well as dealing with the challenges of putting a new team together and the embedding of training and knowledge.

The areas where the provider must make improvements are:

- Have risk assessments in place and up to date for health and safety such as for the premises and equipment.
- The practice must have policies and risk assessments in place such as for detecting and controlling the spread of infections.
- The practice must ensure the recruitment policy is up to date and is followed including for temporary staff.

- The practice must be able to provide a chaperone service for patients in a timely way that does not delay any assessment or treatment needed.

- The practice must have an overall governance arrangement to ensure that all new staff are performing their roles as needed and supported to have further development.

The provider should:

- Have an automated external defibrillator (AED) in place.
- Handle blank prescription forms consistently in accordance with national guidance, whilst they were locked away the access to the keys was not restricted at all times and they were not tracked through the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.

We found areas of concern in recruitment, infection control, medicine management, anticipating events and the management of unforeseen circumstances.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Most staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

There was evidence of appraisals and personal development plans for some staff and were in development for new staff. The staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.

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

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

There was learning from complaints with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led. It had a vision and a strategy but not all staff was aware of this and their responsibilities in relation to it.

There was a documented leadership structure and most staff felt supported by management but at times they weren't sure who to approach with issues.

The practice had a number of policies and procedures to govern activity, but some of these were overdue a review.

There were new staff at the practice, not all had received inductions and systems needed review to ensure all staff had received effective regular performance reviews.

There had also been a decrease in the number of staff meetings and events.

Requires improvement



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 is rated as requires improvement for the care of older people.

Care and treatment of older people did not always reflect current evidence-based practice. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed.

Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients.

The leadership of the practice had started to engage with this patient group to look at further options to improve services for them.

Requires improvement



People with long term conditions

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

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Longer appointments and home visits were available when needed.

However the practice had recently had to employ a locum nurse after the practice nurse and health care assistant left. This meant that at the time we visited the practice there was difficulty in coping with the needs of patients.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.

Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies.

Requires improvement



Summary of findings

However at the time of our inspection the practice had been required to stop immunisation of patients by NHS England. NHS England was developing a plan to enable vaccinations and immunisations to be delivered at other practices in the area.

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including homeless people, with a learning disability. The practice had been able to give annual check-ups to 21 of 22 patients registered with the practice who had learning disabilities.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Most staff knew how to recognise signs of abuse in vulnerable adults and children. Most staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice had responded to the needs of an increasing Nepalese population group by employing a Nepalese speaking receptionist. Two of the GPs could also speak Nepalese.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

Requires improvement



Summary of findings

The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health but not always those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE.

It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Most staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

During our visit we spoke with five patients and reviewed 32 comment cards received from patients who had visited the practice in the previous two weeks. Only three had negative comments of note the rest were highly positive. Patients were complimentary about the practice

staff team and the care and treatment they received. Patients told us they were not rushed, that the appointments system was effective and staff explained their treatment options clearly. They said all the staff at the practice was helpful, caring and supportive.

Areas for improvement

Action the service **MUST** take to improve

- Have risk assessments in place and up to date for health and safety such as for the premises and equipment.
- The practice must have policies and risk assessments in place such as for detecting and controlling the spread of infections.
- The practice must ensure the recruitment policy is up to date and is followed including for temporary staff.
- The practice must be able to provide a chaperone service for patients in a timely way that does not delay any assessment or treatment needed.

- The practice must have an overall governance arrangement to ensure that all new staff are performing their roles as needed and supported to have further development.

Action the service **SHOULD** take to improve

- Have an automated external defibrillator (AED) in place.
- Handle blank prescription forms consistently in accordance with national guidance, whilst they were locked away the access to the keys was not restricted at all times and they were not tracked through the practice.

North Camp Surgery

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, a specialist advisor practice manager, a pharmacist specialist advisor and a second CQC Inspector.

Background to North Camp Surgery

North Camp Surgery, 2 Queens Road, Farnborough, Hampshire, GU14 6DH is a converted dwelling that was extensively extended in 2001. The practice is located on the outskirts of Farnborough. The practice covers a diverse community incorporating a large proportion of ethnic minorities, including Nepalese, pockets of deprivation and army families. The practice is on the ground floor with disabled access.

The practice at the time of our visit had three GPs, two male partners and a salaried female GP. The practice has around 4,600 patients and operated under a personal medical services (PMS) agreement. All the consulting rooms and waiting areas afforded good disabled access. The practice manager started working at the practice in February 2015 and there was a locum practice nurse at the practice. The practice was advertising for a new practice nurse and health care assistant and had recently employed new administration and reception staff.

The practice offered a proportion of pre-bookable appointments available four weeks in advance. Book-on-the-day appointments were available on a first come basis. Patients could ring from 8.00am for morning appointments and 2pm for afternoon appointments. The

practice also provided telephone consultations. GP surgeries ran Monday to Friday from 8.30am until midday and from 2.30pm until 6.00pm. The practice had two telephone lines which helped to make it easier for patients to contact the practice. There were extended hours on Tuesdays until 7.30pm and once a month on a Saturday.

Out of Hours urgent medical care was provided by Frimley Out of Hour's service when the practice was closed.

The practice at the time of our visit had been required by NHS England to not carry out any immunisations until the outcome of an investigation.

Why we carried out this inspection

We carried out a comprehensive inspection of this service in response to concerns about the service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the practice to send us information about them, including their statement of purpose, how they dealt with and learnt from significant events and the roles of the staff. We carried out an announced visit on 11 May 2015.

Detailed findings

During our visit we spoke with a range of staff including GPs, practice nurses, the practice manager, administration staff and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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).

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw that those complaints that had been recorded were dealt with promptly and contained full information.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice conducted significant events meetings each year. These meetings were attended by all the GPs and members of staff involved.

These systems had been used to ensure significant events were reviewed, and action taken when needed and included root cause analysis to identify any trends. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. The practice did have weekly clinical meetings but these had stopped in April 2015 whilst the practice was going through a period of re organisation as a result of a significant event and investigation by NHS England. The practice at the time of our visit had been required by NHS England to not carry out any immunisations until the outcome of an investigation.

Reliable safety systems and processes including safeguarding

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children who had received training up to level three. All the GPs at the practice had also received higher level safeguarding training.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example if a child was subject to a child protection plan. Patient appointments were conducted in the privacy of individual consultation rooms.

Safeguarding policies and procedures for children and vulnerable adults had been implemented by the practice. Staff were aware who the lead was and knew how to recognise signs of abuse in older people, vulnerable adults

and children. They were also aware of their responsibilities and knew what to do if they encountered safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Staff were also aware of the practice "whistleblowing" policy and understood it.

The practice offered patients the services of a chaperone during examinations if required. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. We saw that details of this service were contained in the practice leaflet and how to ask for a chaperone if required. At the time of our inspection this facility had been changed as the practice had no health care assistant in place and a locum nurse was employed.

The salaried GP told us that she was able to perform this role and patients who required a chaperone were given appointments when this GP was available. Due to changes in staffing this meant that some patients may have delayed assessment and treatment. For example the practice had been similar to the national average for the percentage of women aged 25 or over and who had not attained the age of 65 whose notes recorded that a cervical screening test had been performed in the preceding five years. Without proper chaperoning in place some patients may delay assessment and treatment.

Medicines Management

We checked medicines stored in the treatment room and medicine refrigerators and found that whilst stored securely all staff could access the medicines. Practice staff monitored the refrigerators' temperatures and appropriate records were kept.

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

Administration of vaccines was not currently available at the practice. Whilst the practice had approved Patient Group Directions (PGDs) for immunisation, a number were for use in different geographical areas. There were also appropriate arrangements in place for the nurses to administer medicines that had been prescribed and dispensed for patients.

Are services safe?

There was a system in place for the management of high-risk medicines, which included regular monitoring in line with national guidance and appropriate actions were taken based on the results. Staff told us that when a repeat was requested for a medicine not “on repeat” including high-risk medicines, they would generate the prescription in anticipation of signing by the GP. Whilst most prescriptions were for 28 days, prescriptions of shorter durations were issued where clinically appropriate.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that this process was working in practice. Blank prescription forms were not handled consistently in accordance with national guidance, whilst they were locked away the access to the keys was not restricted at all times and they were not tracked through the practice.

Equipment

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurses to ensure the equipment was working and the medicines were in date so that they would be safe to use in an emergency. We noted that the practice did not have an automated external defibrillator (AED) in place.

Regular checks were undertaken on the equipment used in the practice. Examples of recent calibration checks of equipment by a contactor were seen.

Cleanliness and infection control

All areas of the practice appeared to be well maintained, clean and fit for purpose. An infection control policy and supporting procedures was available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment which included disposable gloves and aprons was available for staff to use and staff were able to describe how they would use these in order to comply with the policy. This policy had been updated by the practice nurse in May 2015 who had since retired. However the practice was unable to produce any recent infection control audits.

Hand hygiene techniques were displayed by sinks in staff and patient toilets. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Sharps boxes were provided and were positioned out of the reach of small children.

Clinical waste was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed.

The practice employed a cleaner who was responsible for the general cleaning of the practice. Although we could see that the practice was kept clean and tidy there were minimal records and cleaning schedules and no records in relation to control of substances hazardous to health (COSHH).

Staffing and recruitment

The practice manager and GPs we spoke with told us that they had recently had a number of changes in their experienced work force and this had posed challenges to providing a safe environment for their patients. The practice had employed new staff and was in the process of recruiting a new practice nurse and health care assistant. The provider had employed a locum practice nurse in the interim.

The provider had a suitable process for the recruitment of all clinical and non-clinical staff. The practice carried out pre-employment checks which included evidence of satisfactory conduct in previous employment and, where required, criminal record checks, using the Disclosure and Barring Service (DBS). However we found that the recruitment policy was not always followed with regards to DBS checking and although the locum nurse had been supplied by an agency, the practice had not obtained any information from the agency about the background and qualifications of the nurse.

Newly appointed staff received an induction which included explanation of their roles and responsibilities and access to relevant information about the practice including relevant policies and procedures.

There was no clear programme of induction for the nurse. The practice had a record of the duties the nurse was not competent to carry out, but there was confusion about what competencies the nurse was able to do, for example which chronic conditions the nurse was able to deal with. This meant that staff were unsure of which patients to book with the nurse.

Monitoring safety and responding to risk

There were policies in place detailing how to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medicines,

Are services safe?

equipment and the environment. We saw evidence that these checks were being carried but not within the terms of the policy. For example, the practice had not carried out full risk assessments for legionella. The infection control policy had been updated on 7 May 2015 but the practice was unable to provide a recent infection control audit. There was a lead nominated for health and safety and we saw that a health and safety poster was present in the kitchen area but had not been completed with details of the practice lead or contact details.

The fire safety policy had been updated in January 2014 and fire risk assessments had been carried out. There was fire safety training for all staff booked to take place in June 2015.

Staff reported that they would always speak to the practice manager if an accident occurred and ensure that it was recorded. This and all other practice policies were available to all staff at any time via the practice computer system.

Arrangements to deal with emergencies and major incidents

Emergency medicines were available in the practice and; all staff knew of the locations. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw that the practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

However the plan had not been updated since 2007 and on inspection the plan was found to have out of date telephone contact numbers and location of where the practice would continue to work from if there was a disruption to their service.

Staff had taken part in emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice. New members of staff had been booked in for relevant training.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE). The practice had regular meetings where clinical and business issues relevant to patient care, and significant events and complaints were discussed. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of people. The integrated care team met monthly to discuss those patients who were having problems accessing medical or social services, or those whose condition had changed, warranting a reassessment of their needs.

Management, monitoring and improving outcomes for people

The practice actively used the information they collected for the Quality and Outcomes framework QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma, diabetes and heart failure. They were also ensuring childhood immunisations were being taken up by parents. The practice achieved 91.7% in the 2013-2014 QOF.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included a five yearly smear audit completed in June 2014 and an audit of vitamin D prescribing. We also saw Quality, Innovation, Productivity and Prevention (QIPP) a programme in relation to prescribing and medicines management in conjunction with the North East Hampshire and Farnham clinical commissioning group.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for areas such as the management of respiratory (breathing) disorders. Our review of the clinical meeting minutes confirmed that this happened.

Patients with conditions such as diabetes, asthma and epilepsy were seen and had regular reviews even if they were under hospital care. The previous practice nurse had run clinics for asthma, diabetes and chronic obstructive

pulmonary disease. The practice had been active in immunisation campaigns for flu, shingles and pneumonia. At the time of our inspection the practice had employed a locum practice nurse, there was some confusion about what competencies the nurse was able to do, for example which chronic conditions the nurse was able to deal with.

Effective staffing

There appeared to be enough qualified, skilled and experienced staff to meet patient needs. The practice had three GPs, a locum practice nurse who was employed in April 2015, reception and administration staff including a practice manager who had joined the practice in February 2015, all staff worked flexibly at the practice to cover duties when staff were away from work due to sickness or leave. We observed all staff working professionally and there was a friendly atmosphere at the practice. Staff we spoke with told us that the staffing levels were suitable for the size of the service.

Staff received appropriate support and professional development. The provider had identified training modules to be completed by staff which included amongst others safeguarding of children and vulnerable adults. Staff were aware of and had received information about safeguarding and training in infection control and basic life support skills. Staff received supervision and an annual appraisal of their performance.

Staff we spoke with all told us that although they had only worked at the practice for a short time they felt well supported by their colleagues and the practice manager. They said they had been supported to attend training courses to help them in their professional development and that there was a culture of openness and communication at the practice and they felt comfortable to raise any concerns or discuss ideas.

Working with colleagues and other services

We found the GPs and locum nurse at the practice had worked closely as a team during a period of change and challenges. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients.

The practice continued to work closely with other health care professionals and charities. During our visit to the practice we met a counsellor from Talk Plus. Talk Plus is a team of therapists, counsellors and psychologists who

Are services effective?

(for example, treatment is effective)

helped with many common problems including depression, anxiety, panic, phobias and low self-esteem. The counsellor told us that this practice worked well with Talk Plus.

Staff told us they felt they worked well as a multidisciplinary team and there was good involvement of other social and healthcare professionals especially in the care of older patients and families.

Information sharing

Staff we spoke with were able to explain the training they had received about information sharing. An example given was that when insurance companies requested details of patient notes no information was released without first obtaining full consent from the patient and checking with the clinical staff.

Confidential patient data was shared within the healthcare team at the practice and with other healthcare professionals to whom a patient was referred.

Confidential and identifiable information relating to patients was not disclosed to other individuals without the patient's explicit consent, unless it was a matter of life and death or there was a serious risk to the health and safety of the patient.

Information was shared between the out of hour's service and the practice. Any information received by the practice from the out of hour's service was discussed by GPs the following morning and action taken as appropriate.

The Information governance lead was the practice manager and the practice Caldicott Guardians were one of the GPs and the practice manager.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Patients told us that they understood about giving consent and did not feel pressured into agreeing to treatment.

Staff demonstrated an understanding of the Gillick competence when asked about treating teenage patients. The Gillick competency test was used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions. For example, when emergency contraception was requested.

Health promotion and prevention

We noted the GPs used their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, the practice offered contraception and sexual health services including undertaking chlamydia screening with the national programme. Having identified a need for increased services the female GP had recently completed a diploma in family planning in order to undertake coil fittings at the practice in the future. The practice also ran cervical screening clinics.

The practice ensured that, where applicable, people received appropriate support and advice for health promotion. Information available to patients was effective; there was an extensive pin-board on the wall in the waiting room which was tidy, up to date, and contained notices relevant to the demographics of the patients.

Information was available in easy to read formats and the practice had systems available on their web site for patients whose first language was not English.

The practice had offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the area and again there was a clear policy for following up non-attenders by the practice nurse. At the time of our visit immunisation and vaccinations had been suspended.

NHS England was developing a plan to enable vaccinations and immunisations to be delivered at other practices in the area.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Staff said they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. There were no queues at the desk, and patients were directed swiftly. The reception was accessible to patients with disabilities with lower desk height for wheelchair users. There were signs that asked for patients to respect the privacy of other patients.

The practice had a system that the receptionist took phone calls at the desk only when all the phones in the back office were busy, confidentiality was maintained as at no time did they mention any name or diagnosis or treatment.

The practice ensured that the Out of Hours service was aware of any information regarding their patients' end of life needs. This meant that patients at all stages of their health care were treated with dignity, privacy and compassion.

Care planning and involvement in decisions about care and treatment

All the patients we spoke with and the comment cards completed were complimentary of the staff at the practice and the service received.

Patients said that they felt listened to and involved in the decisions about the care and treatment. Patients expressed

their views and were involved in making decisions about their care and treatment. Patients were given appropriate information and support regarding their care or treatment. Patients told us that the GPs took time to explain things to them. Patients said they had the opportunity to ask additional questions if they needed to and felt their concerns were listened to.

The practice used choose and book for referrals and this allowed some flexibility in access to secondary care for patients and involved them in decisions about care and treatment.

Patient/carer support to cope emotionally with care and treatment

The practice supported patients following discharge from hospital. Discharge letters were monitored and patients were supported on returning home. Patients were contacted by the practice and care and treatment needs were followed up.

The practice was able to refer patients to bereavement services and talking therapy and had visited families who had suffered bereavement.

GPs supported the elderly in local care homes and were assigned care homes to be responsible for.

The practice reported that in the last year they had provided health checks for 21 of the 22 patients with learning disabilities registered with the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a patient participation group and worked with them to produce a practice survey for the wider practice population.

A patient survey on behalf of NHS England undertaken at the end of 2014 showed that patients were happy with the service and that it met their needs. The survey showed that 85% of respondents usually waited 15 minutes or less after their appointment time to be seen, the local average was 68%. The survey showed that 92% of respondents found it easy to get through to the practice by telephone compared to the local average which was 76% and 88% of respondents described their experience of making an appointment good compared to the local average of 79%. This was confirmed in our discussions with patients and from the comment cards submitted by patients attending the practice on the day of our visit.

The patient survey showed that the practice could improve in areas such as time given by GPs for consultations, always involving patients fully in decisions about care and the way in which the GPs treated them with care and concern.

The practice had also seen an increase in the Nepalese population and had responded by employing a Nepalese speaking receptionist. Two of the GPs were also able to speak Nepalese. We also saw that information displayed in the waiting areas were translated into Nepalese

The practice had instigated a programme to deliver annual health checks for a number of patients with learning disabilities. These patients had findings and recommendations incorporated into their personal care plans. In the last year the practice had seen 21 of the 22 registered patients.

Tackling inequity and promoting equality

The practice was situated in converted premises which provided adequate access requirements for disabled patients. All consulting rooms were on the ground floor. The reception was accessible to patients with disabilities with lower desk height for wheelchair users

The practice had recognised the needs of different groups in the planning of its services. There was a system in place for flagging whether a patient was at risk of abuse.

For patients whose first language was not English, the practice had access to online and telephone translation services.

Patients with mental health issues and dementia had care plans which were reviewed in order to check their physical, emotional and care needs were met. The practice identified carers and ensured they were supported. Patients at risk or in crisis were seen and assessed urgently.

All the clinical staff used dementia screening tools to improve detection of those patients early in their illness to ensure early referral. The practice shared care protocols for prescribing dementia medication and liaised with community psychiatry teams.

Access to the service

The practice offered a proportion of pre-bookable appointments available four weeks in advance. Book-on-the-day appointments were available on a first come basis. Patients could ring from 8.00am for morning appointments and 2pm for afternoon appointments. The practice also provided telephone consultations. GP surgeries ran Monday to Friday from 8.30am until midday and from 2.30pm until 6.00pm. The practice had two telephone lines which helped to make it easier for patients to contact the practice.

There were extended hours on Tuesdays until 7.30pm and once a month on a Saturday.

If a patient needed to be seen urgently, they were always seen on that day. The practice endeavoured to see young children and elderly patients on the same day as required.

If necessary, an advocate and/or translator could be booked in advance and the practice had a Nepalese staff member who was able to translate for patients.

Patients said that getting an appointment was easy and usually they were at a time and day that they wanted. While we were visiting a patient attended the practice asking for an appointment, when offered one straight away the patient said it was too soon and booked an appointment for another day.

The premises and services had been adapted to meet the needs of patients with disabilities. The reception area had been designed to have lower levels for patients in

Are services responsive to people's needs?

(for example, to feedback?)

wheelchairs or on mobility scooters to be able to speak with the receptionist at the same level. All the corridors were wide enough for wheelchair users and there were accessible toilet facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

Complaints received by the practice were responded to in a timely manner. However audits were not undertaken

regularly to monitor how effective the process was and whether any themes identified had been addressed. The practice manager was aware of the complaints policy but was not sure of what to do in areas of the policy.

A complaints leaflet was available from the reception desk and contained information on referring the complaint to the Parliamentary Ombudsman if the complainant was not satisfied with the response from the practice. This leaflet appeared to have been produced several years ago and required updating as organisations and contact telephone numbers had changed.

The complaints procedure was also outlined in the patient information booklet.

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

Staff were committed to the practice aims and described the ethos of the practice as being focused on high quality patient care. The practice had a vision and strategy that placed the quality of patient care as their priority. The practice values and aims were described as being patient centred and providing a caring service to patients.

The practice statement of purpose outlined the practice purpose was to provide patients registered with the practice with personal health care of high quality and to seek continuous improvement on the health status of the practice population overall. The practice aimed to achieve this by developing and maintaining a happy sound practice which is responsive to people's needs and expectations and which reflected whenever possible the latest advances in Primary Health Care.

Staff told us the practice had an open and democratic way of working to ensure that everybody felt part of the team. In our discussions with the locum nurse and non-clinical staff effective communication was a goal, and that there was a caring ethos of putting patients first that resulted from the GP leadership.

Recent events had meant that a number of new staff had been recruited and the practice needed time to allow the smooth running of practice to be resumed.

There were new staff at the practice, not all had received full inductions and systems needed review to ensure all staff had received effective regular performance reviews. There had also been a decrease in the number of staff meetings and events.

Governance arrangements

We saw good working relationships amongst new staff and an ethos of team working. Partner GPs and the salaried GP had areas of responsibility, such as; infection control or safeguarding. It was therefore clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards.

We reviewed a number of policies, for example, complaints handling protocol and recruitment policy in place to support staff. Staff told us they knew where to find these policies if required. However we found that policies had not been updated regularly for example the business continuity plan had out of date contact numbers and locations.

Leadership, openness and transparency

We were shown a leadership structure which had named members of staff in lead roles. For example the salaried GP was the lead for safeguarding. We spoke with five members of staff who were learning about their own roles and responsibilities but were not always clear about how the practice worked. For example the practice manager was unsure about how to deal fully with complaints. They all told us that felt valued, supported and knew who to go to in the practice with any concerns.

We were told that team meetings had not taken place but we saw that there had been clinical meetings.

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

The practice was unable to produce evidence that the practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would give feedback and discuss any concerns or issues with colleagues and management.

There was no evidence that the practice had gathered feedback from patients such as through patient surveys, comment cards.

The practice had a patient participation group and the practice worked with them to help improve the care services for patients. Patients we spoke with and the comment cards patients had completed were complimentary about the staff at the practice and the service that patients had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

Management lead through learning and improvement

The practice undertook and participated in a number of regular audits. We saw that recently incidents had been reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly.

Are services well-led?

Requires improvement



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

We found that this practice had recently had to adapt to a great number of changes to staff in the last six months having had a new practice manager and losing several key members of clinical and administration staff.

The GP partners and salaried GP said they were committed to working to keep a high level of patient service as well as dealing with the challenges of putting a new team together and the embedding of training and knowledge.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Patients were not always protected from the risk of infection because appropriate guidance had not always been followed. Processes and procedures were in place. However, the provider had not audited the infection prevention and control processes to assess the risks to the health and safety of service users receiving care or treatment and do all that is reasonably practicable to mitigate any such risks.</p> <p>Patients were not protected as there were no assessments of the risks to health and safety of service users receiving care or treatment.</p> <p>This was a breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in Regulation 19(1)(b)</p> <p>The provider had not ensured that staff including locums providing care or treatment to service users had the qualifications, competence, skills and experience which are necessary for the work to be performed by them.</p> <p>This was a breach of Regulation 19(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The Care and treatment of service users must-(a) be appropriate, (b) meet their needs and (c) reflect their preferences.

The practice must be able to provide a chaperone service for patients in a timely way that does not delay any assessment or treatment needed.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service.

Information should be up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate action taken.

The practice had not ensured that all policies and procedures to govern activity and assess quality including staff performance were up to date, implemented and reviewed.

This was a breach of 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.