

Heath Hill Surgery

Quality Report

**54 Heath Hill Road South
Crowthorne
Berkshire
RG45 7BN**

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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?

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

Heath Hill Surgery is located in a semi-rural area of Crowthorne in Berkshire. It provides primary medical services to approximately 7200 registered patients.

We carried out an announced, comprehensive inspection on 23 October 2014. We visited the practice location at 54 Heath Hill Road South, Crowthorne, Berkshire RG45 7BN

Heath Hill Surgery was rated as requires improvement overall.

Our key findings were as follows:

- The practice is rated as requires improvement for safe. We identified minor areas of concern regarding an understanding of child protection, adherence to infection control practices and the temperature of hot water in the patients' toilets.
- The practice is rated as requires improvement for effective. We identified areas of concern relating to the lack of leadership in prescribing. Data showed patient outcomes were at or above average for the locality.

- The practice is rated as good for caring. Feedback from patients and survey data showed the practice performed above the clinical commissioning group (CCG) and national averages on patient satisfaction.
- The practice is rated as good for responsive. Patients reported good access to the practice for urgent/ same day appointments but were not always able to access routine appointments with their named GP.
- The practice is rated as requires improvement for well-led. We identified one area of concern relating to the lack of robust assessment and monitoring of the quality of the service provision. The practice had an active patient participation group (PPG) whose role was valued in improving patient care.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Protect patients and others who may be at risk of inappropriate or unsafe care and treatment, by means of the effective operation of quality assessment and monitoring systems.

Summary of findings

We have issued one compliance action for the regulation relating to assessing and monitoring the quality of service provision.

In addition the provider should:

- Ensure staff are familiar with child protection procedures

- Ensure there is appropriate leadership to review prescribing and promote best practice.
- Ensure fridge temperatures are monitored daily

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 safe. We identified minor areas of concern regarding an understanding of child protection, adherence to infection control practices and the temperature of hot water in the patients' toilets. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Staff recruitment processes were effective and followed. Medicines were handled safely, although there were regular occasions when the fridge temperature was not monitored. Emergency procedures were in place and staff had received training in how to respond.

Requires improvement



Are services effective?

The practice is rated as requires improvement for effective. We identified areas of concern relating to the lack of leadership for prescribing within the practice. We reviewed a sample of patient records which contained a number of out of date pop-up alerts, relating to medicines, which had not been closed. Data showed patient outcomes were at or above average for the locality. Patients' needs were assessed and care was planned and delivered in line with local and national guidance. This included assessment of capacity and the promotion of good health. Staff were trained appropriate to their roles and further training needs were identified and planned. The practice staff had participated in appraisals and had opportunities for development in their roles. Multidisciplinary working was evidenced.

Requires improvement



Are services caring?

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. Patients reported good access to the practice for urgent/ same day appointments but were not always able to access routine appointments with their named GP. The practice environment made it difficult for people in

Good



Summary of findings

wheelchairs or those who had mobility difficulties. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

The practice is rated as requires improvement for well-led. We identified one area of concern relating to the lack of robust assessment and monitoring of the quality of the service provision. The practice vision was clearly stated on the website and booklet. The practice proactively sought feedback from patients through an active patient participation group (PPG). All staff received regular performance reviews and were supported through training.

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 care provided to older people. We identified areas of concern relating to the lack of robust assessment and monitoring of the quality of the service provision. The practice had a higher proportion of older patients compared to the clinical commissioning group (CCG) and national averages. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia. The practice was responsive to the needs of older people, including offering home visits and prioritised patients with complex needs. Safeguarding policies and procedures were in place to identify patients at risk of abuse. The practice had achieved and implemented the gold standards framework for end of life care.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the population group of people with long term conditions. We identified areas of concern relating to the lack of robust assessment and monitoring of the quality of the service provision. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients with complex conditions were discussed at multidisciplinary meetings and an appropriate care plan developed. Thirty eight out of 44 patients with heart failure had an annual medicine review.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the population group of families, children and young people. We identified areas of concern relating to the lack of robust assessment and monitoring of the quality of the service provision. The practice 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 the average for the CCG. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. We were provided with good examples of joint working with midwives, health visitors and school nurses. Two patients told

Requires improvement



Summary of findings

us they were very satisfied with the antenatal care provided. The practice provided care and treatment to the children of a local boarding school. Staff at the school told us they were very satisfied with the standard of service they received.

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the population group of the working-age people (including those recently retired and students). We identified areas of concern relating to the lack of robust assessment and monitoring of the quality of the service provision. The practice had a lower proportion of patients between the ages of 20-39 years. 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 offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. For example, the practice achieved 46% NHS Health Checks for 40-75 year old patients. The practice had also identified the smoking status of 79% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to those patients. There was evidence these were having some success as the number of patients who had stopped smoking in 2013/14 was 70%.The practice offered pre-booked appointments on alternate Saturday mornings and telephone consultations.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. We identified areas of concern relating to the lack of robust assessment and monitoring of the quality of the service provision. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and 25 out of 27 of these patients had received a follow-up. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Requires improvement



Summary of findings

People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). We identified areas of concern relating to the lack of robust assessment and monitoring of the quality of the service provision. Twenty four out of 34 patients with poor mental health had a care plan in place. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had a system in place to follow up on patients who had been discharged from hospital to support them in the community.

Requires improvement



Summary of findings

What people who use the service say

The 2014 national GP survey results for Heath Hill Surgery based on 119 (45%) responses showed the practice was better in all areas relating to interactions with the practice nurse, compared to the local clinical commissioning group (CCG) average. The practice performed less well on scores of good for patients' experience of making an appointment; 58% compared to the CCG average of 72%. The practice participation group (PPG) conducted face to face interviews with 90 patients in 2013. They reported 84 out of 90 patients were satisfied with the service offered. The main issue highlighted was the lack of availability of routine appointments.

During the inspection on 23 October 2014 we spoke with seven patients. All the patients we spoke with were very satisfied with the care they received. Although, patients told us urgent appointments were offered, four out of seven patients expressed difficulty in obtaining routine appointments. We received 17 comment cards from patients who had visited the practice over the previous two weeks. Fourteen of the comment cards expressed gratitude and praise for the care provided by the staff. Three comment cards showed some dissatisfaction with the delays in obtaining routine appointments. This was consistent with our findings from the survey results and what patients told us during the inspection visit.

Areas for improvement

Action the service **MUST** take to improve

- Protect patients and others who may be at risk of inappropriate or unsafe care and treatment, by means of the effective operation of quality assessment and monitoring systems.

Action the service **SHOULD** take to improve

- Ensure staff are familiar with child protection procedures
- Ensure there is appropriate leadership to review prescribing and promote best practice.
- Ensure fridge temperatures are monitored daily

Heath Hill 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 specialist advisor, an Expert by Experience and two specialists: one in practice management and one in practice nursing.

Background to Heath Hill Surgery

Heath Hill Surgery is located in a three storey premises in a semi-rural area. It provides primary medical services to approximately 7200 registered patients. The practice has 18 staff, including five GP partners (one partner is salaried); two male GPs and three female GPs, practice nurses, administration, reception and management staff. The practice has a higher proportion of patients over the age of 40 years and between 10-15 years compared to the local clinical commissioning group (CCG) average and a lower proportion in 20-39 years age group. The practice serves a population which is more affluent than the national average.

We visited the practice location at 54 Heath Hill Road South, Crowthorne, Berkshire RG45 7BN

The practice has opted out of providing out-of-hours services to its own patients and uses the services of a local out-of-hours service. The practice holds a General Medical Services contract.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Prior to the inspection we contacted the Bracknell and Ascot Clinical Commissioning Group, NHS England area team and local Healthwatch to seek their feedback about the service provided by Heath Hill Surgery. We also spent time reviewing information that we hold about this practice.

The inspection team carried out an announced visit on 23 October 2014. We spoke with seven patients and eight staff. We also reviewed 17 comment cards from patients who shared their views and experiences.

As part of the inspection we looked at the management records, policies and procedures, and we observed how

Detailed findings

staff interacted with patients and talked with them. We interviewed a range of staff including three GPs, nursing staff, administration, reception and practice management staff.

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

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

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

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

The practice has a higher proportion of patients over the age of 40 years and between 10-15 years compared to the local clinical commissioning group (CCG) average and a lower proportion in 20-39 years age group. The practice serves a population which is more affluent than the national average.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and how to report incidents and near misses. For example, an incident related to a medical emergency following a fitting of an intra-uterine contraceptive device. This resulted in a change in practice to improve patient safety.

We saw the annual incident report and notes of meetings where these were discussed for the last three months. This showed the practice had managed these consistently over time and so could evidence a safe track record over the last year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. They carried out an annual review of significant events. It showed 19 entries between April 2013 and March 2014. A slot for significant events was on the monthly clinical meeting agenda and a dedicated meeting occurred annually to review actions from past significant events and complaints. There was evidence that learning had taken place across GPs and nurses. All staff including receptionists, administrators and nursing staff were aware of the system for raising issues in the practice.

National patient safety alerts were disseminated by the practice manager to relevant staff for action. Staff we spoke with were able to give examples of recent alerts they had received and acted on, for example, regarding a recent blood glucose meter issue.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities

regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. Contact details were easily accessible. However, we identified one area of concern during discussions with a nurse; they did not immediately identify a scenario where a 12 year old child presented for contraceptive advice as a child protection issue.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments.

A chaperone policy was in place and notices available in consulting rooms, although not in the waiting area. Chaperone training had been undertaken by all nursing staff, including health care assistants. One patient told us they recalled being offered a chaperone prior to an examination.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS Web, which collated all communications about the patient including scanned copies of communications from hospitals. Alerts were enabled on the system to highlight vulnerable patients and families.

Medicines management

The practice must improve the way they manage medicines. We found there was no designated prescribing lead to regularly monitor and review prescribing data within the practice. The nurse prescribers did not receive regular supervision and support in their prescribing roles. We reviewed the 2013/14 Heath Hill Surgery prescribing report which showed the practice performance for prescribing antibiotics was above the CCG average. We found the fridge temperature was not always checked, readings were frequently omitted on Tuesdays, when one of the nurses was absent.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

Are services safe?

and were only accessible to authorised staff. 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.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Although the immunisation schedule on display on the fridge was out of date.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Our specialist in practice nursing reviewed a random sample of 17 medical records for patients prescribed warfarin (a blood-thinning medicine). All patients were up to date with blood tests and had appointments booked for their medicine review. However, we found three out of six pop-up alerts were not valid as they were not consistent with the information on the patients' records. For example, in one case the pop-up stated the patient had their blood tested in hospital which was incorrect according to the patient's record.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Cleanliness and infection control

We observed the practice to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice's lead for infection control was the senior partner. All staff received induction training about infection control specific to their role and there after annual updates. An infection control audit had been carried out in

the last six months and actions implemented to make improvements. For example, new clinical waste bins had been installed; an action plan was in place to address further issues.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons were available for staff to use. However, we found not all staff adhered to the practice policy of not wearing nail polish, whilst providing direct patient care,

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

The practice had a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We identified an area of concern regarding the risk of excessively hot water in the hand wash basins in the male and female toilets. Although, in the female toilets a sign was in place advising patients not to adjust the temperature control, in the male toilets there was no sign to deter or prevent people from increasing the temperature.

The practice offered a phlebotomy service, however it did not have a chair specifically designed for phlebotomy (taking blood). The practice offered the couch to patients who were known to be at risk of fainting, whilst having their blood taken.

Staffing and recruitment

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

Are services safe?

references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting GPs, nurses, administration and reception staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. This included monthly checks of the environment and staffing. The practice also had a health and safety policy and health and safety information was displayed for staff to see. Risks were discussed and actions agreed at partners' meetings.

Systems were in place to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, patients with complex conditions or those listed on the practice's 'admission avoidance' register (patients who were at risk of attending the accident and emergency department) were discussed and followed up at least monthly. A system was in place to monitor repeat prescribing and call patients for reviews.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with were aware of the location of this equipment and records we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning had taken place.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks to the service were identified such as 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 suppliers and service companies.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. However, we noted the printed hypertension guidelines, which the health care assistant referred to, were out of date. We saw notes of practice meetings where the practice's performance and patients were discussed and actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs discussed referrals on a daily basis. The practice used a local triage system to manage its referrals for a number of specialities including dermatology and orthopaedics, which were higher than the local clinical commissioning group (CCG) average.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Issues were discussed at monthly clinical meetings. For example, needs of patients on the 'admission avoidance' register. (A list of patients who are at increased risk of emergency admission to hospital).

We saw data from the local CCG of the practice's performance for antibiotic prescribing which was worse than other practices. The GP special advisor randomly selected 24 records of patients who were overdue a medicine review. We found only two were overdue a review, however, there were several out of date pop-up alerts relating to their medicines.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and diabetes.

The practice showed us five clinical audits that had been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the positive changes resulting since the initial audit. For example, in minor surgery documentation.

The practice also used the information they collected for the quality and outcomes framework (QOF). QOF is a national performance measurement tool. QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 77% of patients with diabetes had an annual review, and the practice achieved 98% in the clinical domain, which was higher than the national average.

GPs and nurses discussed patients on the 'admission avoidance' register monthly to agree strategies to monitor and review those patients' needs.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up medicines alerts when the GP went to prescribe medicines. However, we found several occasions when out of date alerts were displayed which indicated they had not been actioned or closed appropriately.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area. For example, the practice monitored accident and emergency attendance and was found to be below the benchmark target.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller

Are services effective?

(for example, treatment is effective)

assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example, National Vocational Qualifications in reception and management.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, intra-uterine contraceptive device (IUCD or coil fitting). Nurses supported each other through weekly meetings.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service were received electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held monthly multidisciplinary team meetings with members of the primary health care team, including district nurses and health visitors to discuss the needs of patients with complex needs and vulnerable patients, for example, those with end of life care needs or children on the at risk register. Meeting notes indicated this forum worked well as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was

a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

The practice had systems in place to provide staff with the information they needed. An electronic patient record, EMIS Web was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the GP and nursing staff we spoke with understood how they implemented it in their practice.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All GPs and nurses demonstrated a clear understanding of Gillick competencies. (These help GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). The practice had a consent policy in place and specific information regarding consent of children.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's consent was documented in the patient notes. We were shown an audit that confirmed the consent process for minor surgery had been followed in 100% of cases.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. All patients had a named GP to facilitate continuity of care. The senior GP told us the practice promoted a holistic approach to care and GPs and nurses maximised contact with patients to maintain or improve mental, physical health and wellbeing. For example, the practice achieved 46% NHS Health Checks for 40-75 year old patients. The practice had also identified the smoking status of 78.8% of patients over the age of 16 and

Are services effective?

(for example, treatment is effective)

actively offered nurse led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in 2013/14 was 70%.

Patients with complex conditions were discussed at multidisciplinary meetings and an appropriate care plan developed. Thirty eight out of 44 patients with heart failure had an annual medicine review.

The practice's performance for cervical smear uptake was 85.7% which was better than others in the CCG. The

practice 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 CCG. Two younger patients told us they were very satisfied with the antenatal care provided.

A large number and range of information leaflets on health conditions and organisations were available in the waiting area and accessible via the practice website.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. The 2014 national GP survey results for Heath Hill Surgery based on 119 (45%) responses showed the practice was better in all areas relating to interactions with the practice nurse, compared to the local clinical commissioning group (CCG) average. The practice performed less well on scores of good for patients' experience of making an appointment; 58% compared to the CCG average of 72%. The practice participation group (PPG) conducted face to face interview with 90 patients in 2013. They reported 84 out of 90 patients were satisfied with the service offered; the main issue highlighted was the lack of availability of appointments.

During the inspection on 23 October 2014 we spoke with seven patients; older and younger. All of them had family members who were also patients of the practice and were able to recount their experiences as well. All the patients we spoke with were very satisfied with the care they received. Although patients told us urgent appointments were offered, four out of seven patients expressed difficulty in obtaining routine appointments. Two patients said some GPs and nurses were more compassionate than others. We received 17 comments cards from patients who had visited the practice over the previous two weeks. Fourteen of the comment cards expressed gratitude and praise for the care provided by the staff. Three comment cards showed some dissatisfaction with the delays in obtaining routine appointments. This was consistent with our findings from the survey results and what patients told us during the inspection visit.

During the inspection visit we observed there were areas in the practice where breaches of privacy or confidentiality occurred: Although, consultations took place behind closed doors, we could overhear conversations in the corridor outside which was also a small waiting area for patients. In one of the cupboard's in the treatment room, a list of patients names was displayed which could be seen by patients in the treatment room. The computer screen at the reception desk was visible by other patients waiting at the desk. Privacy was compromised in the male toilets if the light was on or if the curtain was moved away from the plain glass window, which overlooked the car park.

Patients seated in the waiting area were called for their appointment by their name on a screen and a beep sound. If patients did not respond a GP or nurse came out and called them personally. 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.

All administration, reception and practice management staff wore name badges. During the inspection we witnessed a number of caring and discreet interactions between staff and patients to preserve their dignity and privacy. The practice scored above the CCG average for the level of privacy when speaking to receptionists at the practice

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed the practice was rated above the CCG average for GPs and nurses involving patients in decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who needed language support. However, the GPs we spoke with did not routinely consider the use of independent translation services when the patient was accompanied by a relative or friend who acted as a translator.

Patients with learning disabilities and those with mental health conditions were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or

Are services caring?

more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, the practice kept a register of all patients with learning disabilities and all were offered an annual physical health check, 25 out of 27 patients had received a check and also had a care plan in place. Twenty four out of 34 patients with mental health problems had care plans in place.

Patient/carers support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received indicated patients were very positive

about the emotional support they were offered. Especially, for example following bereavement. Three out of seven patients we spoke with on the day mentioned the emotional support provided by the staff including following bereavement. Two comments cards also highlighted the emotional and compassionate care provided following bereavement.

There was a large and wide range of leaflets and notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw the written information available for carers to ensure they had access to the various sources of support available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice has a higher proportion of patients over the age of 40 years and between 10-15 years compared to the local Bracknell and Ascot Clinical Commissioning Group (CCG) and national averages and a lower proportion in 20-39 years age group.

All patients had a named GP to ensure a degree of continuity of care. However, patients said there were delays in obtaining routine appointments with their named GP. Longer appointments were available for patients who needed them. Home visits were made to two care homes once a week and to patients who needed one. For example, patients who were too frail or physically unable to attend the practice. The senior GP also regularly provided care and treatment to the children of a local boarding school. Staff at the school told us they had found the practice to be very helpful and flexible in meeting the needs of the school children. For example, arranging appointments at convenient times.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). For example, allowing patients to book appointments four weeks in advance and providing text reminders for appointments.

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

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. For example with the out-of-hours service provider.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The practice provided equality and diversity training via e-learning. The majority of staff had received equality and diversity training.

The practice was located on three floors with patient areas on two floors, access by way of a narrow staircase. This posed some difficulty for patients with mobility difficulties or in wheelchairs. Consultations were offered downstairs for patients who could not manage the stairs. The high reception desk also made it difficult for reception staff to interact with patients in wheelchairs.

Access to the service

The practice was open 8am to 6.30pm weekdays; GP appointments were available between 8.20am to 12.30pm and 3.50pm to 5.40pm and nurse appointments for different time slots. The nurse practitioner carried out daily triage 8am to 12pm daily. The duty GP saw all patients on the day and other GPs saw patients with pre-booked appointments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice has a higher proportion of patients over the age of 40 years; working age commuters. The practice offered pre-booked appointments on alternate Saturday mornings aimed at this group of patients. Telephone consultations were also available.

Patients were generally satisfied with the appointments system for same day/urgent appointments. However, patient feedback indicated routine GP appointments were more difficult to obtain.

Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The waiting area had two chairs with armrests. At busy times, we observed some older patients had difficulty rising from chairs without armrests.

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, for example a poster displayed at the entrance to the practice and information

on the website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at 13 complaints received in 2013 and found they had all been investigated and resolved. The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learnt from individual complaints had been acted upon. Staff told us verbal complaints were more frequent than written complaints but they were not monitored or recorded. Staff were able to give examples of changes to procedures as a result of 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 had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision were part of the practice's one year business plan. The practice vision and values were stated in the practice charter on the website and booklet. They included working with patients to provide appropriate and respectful care.

Governance arrangements

We found the practice did not have robust arrangements for identifying, recording and managing all risks in the service. For example, concerns identified during the inspection included hot water temperatures in the patients' toilets, a potential breach of privacy in the male toilets, all staff not adhering to the practice infection control procedure, the lack of prescribing leadership, the gaps in fridge temperature checks and the out of date pop-up alerts on the computer. The practice manager had an extensive action plan in place, however timeframes for completion were not recorded.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at nine of these policies and procedures, two policies had cover sheets which listed staff names and signatures to confirm they had read the policy and when. All the policies and procedures we looked at had been reviewed in the previous two years and some had review dates listed.

The practice held monthly clinical meetings. We looked at notes from the last three meetings and found that performance and risks had been discussed. However, two GPs said there was not enough discussion within meetings and not enough meetings for all staff.

The practice had completed a number of clinical audits, for example minor surgery and diabetes audit.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, the senior partner was the lead for infection control, one GP

was the lead for safeguarding children. We spoke with eight members of staff and they were all clear about their own roles. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Clinical and primary health care team meetings were held monthly. Reception and administrative staff told us communication in the practice was primarily informal. Reception meetings had recently been held in August 2014 and there was a plan to schedule them regularly. There were no practice wide meetings where all GPs, nurses, reception and administrative staff participated. A quarterly staff bulletin was circulated to share practice news. Meetings for GPs and nurses with the practice management team took place regularly, however, there was no forum for reception and administration staff.

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

The practice had gathered feedback from patients through patient surveys and complaints received. The practice had a well established, active patient participation group (PPG) of eight members. The PPG met every two months with a practice representative. The PPG annual report, surveys and quarterly newsletter was published on the practice website. We reviewed the notes of the last PPG meeting and noted the high level of transparency between the PPG and practice. For example, they discussed non-clinical complaints and practice development. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. For example, allowing patients to book appointments four weeks in advance and implementing text reminders to patients for appointments.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training

Are services well-led?

Requires improvement 

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

and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

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	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p>Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision</p> <p>How the regulation was not being met:</p> <p>Patients who use services and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems because of a lack of robust assessment and monitoring of the quality of the service provision.</p> <p>Regulation 10 (1)</p>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	