Heathcote Medical Centre

Quality Report

Heathcote Medical Centre
Heathcote
Tadworth
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Date of inspection visit: 11 November 2014
Date of publication: 26/03/2015

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?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Heathcote Medical Centre is located in purpose built premises in a semi-rural location. The practice provides services to approximately 12,200 registered patients.

We carried out a comprehensive inspection on 11 November 2014. We visited the practice location at, Heathcote, Tadworth, Surrey, KT20 5TH.

We have rated the practice as requires improvement. The inspection team spoke with staff and patients and reviewed policies and procedures implemented throughout the practice. Processes and procedures were in place to ensure the safety of patients and staff.

Our key findings were as follows:

- Staff were well supported and continuous learning and improvement was encouraged. However, some areas of mandatory training were not up to date.
- Effective communication and information sharing was evident both within the practice staff team and with external services.
- GPs holding lead roles in the management of long term conditions such as diabetes and mental health promoted the use of best practice in order to continually improve the care of patients.
- All patients had a named GP and GPs managed their own personalised lists.
- Patients reported experiencing difficulty in accessing the practice by telephone to make appointments or to speak with staff.
- Patients also reported considerable delays in accessing appointments with their named GP.
- Some patients found reception staff to be unhelpful.
- The practice had taken steps to respond to patient feedback but some of the difficulties experienced by patients remained unresolved.

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

Importantly, the provider must:

- Ensure all staff receive up to date training in mandatory areas such as fire safety and basic life support.

Summary of findings

- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the health, safety and welfare of patients and staff.
- Ensure criminal record checks are undertaken via the Disclosure and Barring Service for nurses and staff trained to provide chaperone services.
- Ensure all remedial works and ongoing monitoring recommendations are implemented in order to reduce the risk of exposure of staff and patients to legionella bacteria.

In addition the provider should:

- Continue to review and improve telephone access to the practice for patients.
- Review and improve access to routine appointments with a named GP.
- Ensure electrical equipment is regularly examined and where required, safety testing is undertaken.
- Ensure staff appraisals include documented input from the appraiser.
- Promote the availability of the chaperone service within consulting rooms.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about incidents was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe. Equipment was available for use in medical emergencies. There were systems to protect patients from the risk of abuse. Risks to staff and patients were not always assessed and well managed. The practice had not undertaken a risk assessment of fire safety and evacuation procedures. Some staff were not up to date with mandatory training in basic life support and fire safety. The practice had identified the risks associated with potential exposure to legionella bacteria which is found in some water systems but had not taken steps to reduce those risks. Chaperone training had been undertaken by some staff. However, reception staff undertaking chaperone duties had not been subject to a criminal records check through the Disclosure and Barring Service and the practice had not undertaken a risk assessment to support this decision.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient needs were assessed and care was planned and delivered in line with current legislation. This included the assessment of capacity and the promotion of good health. Staff were well supported and continuous learning and improvement was encouraged. Many staff had received training appropriate to their roles and further training needs had been identified and planned. GP lead roles in such areas as diabetes, mental health and prescribing promoted the use of best practice and in improving outcomes for patients. The practice had completed appraisals and personal development plans for all staff. There was evidence of multidisciplinary and collaborative working.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for some aspects of care. However, data from the national patient survey showed that the number of respondents who described the overall experience of the practice as good was lower than the national

Summary of findings

average. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Some patients found some of the reception staff to be unhelpful. We found that staff we observed treated patients with kindness and respect, and maintained confidentiality. Information to help patients understand the services available was easy to understand.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. The practice had good facilities and was well equipped to treat patients and meet their needs. Feedback from patients indicated that they experienced delays in accessing appointments with their named GP, although urgent appointments with another GP were usually available on the same day. Patients also reported ongoing problems in reaching the practice by telephone. The practice had reviewed the feedback provided by patients and had taken steps to implement improvements. However, patients reported continuing problems in accessing the practice by phone and in obtaining a timely appointment with their GP of choice. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to support and guide staff with their duties. Staff were well supported to access training and continuous learning and improvement was encouraged. There were processes in place for staff inductions and regular appraisals. Some staff had not received up to date training in mandatory areas such as basic life support and fire safety. Regular meetings with different staff groups took place. The practice sought feedback from staff and patients and had taken steps to act upon this feedback. However, some issues presented ongoing problems for patients such as access to the practice by telephone. The practice had a small patient participation group (PPG) and used the group to seek feedback about new developments or service changes. Risks to staff and patients were not always assessed and well managed.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The provider was rated as good for effective and caring overall and this includes for this population group. The provider was rated as requires improvement for safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as requires improvement for the care of older patients.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. There was good communication between the practice and other services including the community matron, social services and support organisations for carers. The practice had a safeguarding lead for vulnerable adults. The practice monitored daily hospital discharges and accident and emergency admissions to ensure that patients could be contacted and their care reviewed. The practice provided weekly memory clinics as part of their provision of enhanced services to provide timely diagnosis and support to patients with dementia.

People with long term conditions

Requires improvement

The provider was rated as good for effective and caring overall and this includes for this population group. The provider was rated as requires improvement for safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as requires improvement for the care of patients with long term conditions.

When needed, longer appointments and home visits were available for patients with long term conditions. All patients underwent structured annual reviews to check whether their health and medicine needs were being met. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Multidisciplinary meetings took place monthly to discuss patients who may be at risk and those needing palliative care. Appropriate monitoring and reviews were undertaken to support patients with managing their conditions and preventing deterioration in their health.

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Families, children and young people

Requires improvement

The provider was rated as good for effective and caring overall and this includes for this population group. The provider was rated as requires improvement for safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as requires improvement for the care of families, children and young patients.

There were systems in place to identify and follow up children who were at risk. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and where required children were prioritised for urgent same day appointments. The premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. The practice had safeguarding processes to protect children from abuse. Staff were aware of the process and were able to describe what action to take if they suspected abuse or had concerns.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as good for effective and caring overall and this includes for this population group. The provider was rated as requires improvement for safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as requires improvement for the population group of working-age patients (including those recently retired and students).

The needs of working age patients 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 which reflected the needs for this age group. The practice provided late evening appointments on two evenings each week and access to Saturday morning appointments to accommodate the need of working age people.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as good for effective and caring overall and this includes for this population group. The provider was rated as requires improvement for safe, responsive and well-led. The

concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as requires improvement for patients whose circumstances may make them vulnerable.

Some patients in this population group could experience difficulties in accessing the practice by telephone and obtaining a routine appointment to see their named GP. For example, patients who were housebound or homeless. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. Annual health checks were provided for these patients. The practice offered longer appointments for patients with learning disabilities. The practice worked closely with district nurses and the community matron which enabled an improved continuity of care for their housebound patients. The practice regularly worked with multi-disciplinary teams in the case management of adults and children who were vulnerable. The practice had sign-posted these patients to various support groups and voluntary 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.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as good for effective and caring overall and this includes for this population group. The provider was rated as requires improvement for safe, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as requires improvement for patients experiencing poor mental health (including people with dementia).

The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had appointed a lead GP for mental health. They supported staff to continually review and discuss new best practice guidelines for the management of mental health conditions and dementia. The mental health lead GP had been working with the local clinical commissioning group to develop mental health care pathways and further improve the management of mental health conditions within the practice. The practice provided weekly memory clinics as part of their provision of enhanced services to provide timely diagnosis and support to patients with dementia. The practice had safeguarding procedures to protect vulnerable adults, including those with poor mental health. A chaperone service was also available to all patients.

Summary of findings

What people who use the service say

We reviewed recent GP national survey data available for the practice on patient satisfaction. The survey showed that 71% of respondents described the overall experience of the practice as good, compared with a national average of 85%. The survey found that 87% of patients said the last nurse they saw was good at involving them in decisions about their care, compared with a national average of 85%. Only 41% of patients found it easy to get through to the practice on the phone, compared with a national average of 75%. The percentage of patients who were very satisfied or fairly satisfied with the opening hours of the practice was 61% compared with a national average of 79%.

We reviewed the feedback provided about the practice on the NHS Choices website, by 17 patients since November 2013. The practice had been rated by 15 patients with one star out of a possible 5 stars. Many of those patients described unhelpful reception services, an inaccessible telephone system and a high turnover of GPs. Two patients gave the practice high ratings and described the professionalism of the practice nurses and the understanding and helpful reception staff.

We spoke with six patients on the day of inspection and reviewed 18 comment cards completed by patients in the two weeks before the inspection. The comments we reviewed were mostly positive and described the professional, excellent care received by patients. One of the comment cards commented on difficulty accessing the practice by phone in order to make an appointment. Another commented on the unhelpful nature of some reception staff. All of the patients we spoke with on the day of inspection told us that all staff were helpful and professional. All of the patients we spoke with told us about the difficulty in contacting the practice by telephone and the long wait to see a named GP for a routine appointment. One patient told us they were always able to obtain an urgent same day appointment for their children. Two of the patients we spoke with had urgent same day appointments on the day of inspection. They told us they had visited the practice in person early in the morning in order to make an appointment, as it was difficult for them to get through to the practice on the phone.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff receive up to date training in mandatory areas such as fire safety and basic life support.
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the health, safety and welfare of patients and staff.
- Ensure criminal record checks are undertaken via the Disclosure and Barring Service for nurses and staff trained to provide chaperone services.
- Ensure all remedial works and ongoing monitoring recommendations are implemented in order to reduce the risk of exposure of staff and patients to legionella bacteria.

Action the service SHOULD take to improve

- Continue to review and improve telephone access to the practice for patients.
- Review and improve access to routine appointments with a named GP.
- Ensure electrical equipment is regularly examined and where required, safety testing is undertaken.
- Ensure staff appraisals include documented input from the appraiser.
- Promote the availability of the chaperone service within consulting rooms.

Heathcote Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Inspector**.** The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Heathcote Medical Centre

Heathcote Medical Centre offers primary medical services via a general medical services (GMS) contract to approximately 12,200 registered patients. The practice delivers services to a higher number of patients who are aged 65 years and over, when compared with the local clinical commissioning group (CCG) and England average. Data available to the Care Quality Commission (CQC) shows fewer of the registered patients suffering income deprivation than both the local and national average.

Care and treatment is delivered by three GP partners and seven salaried GPs. There is a good mix of male and female GPs. The practice is a training practice and has two trainee doctors, as well as providing support for final year medical students who join the practice for a period on attachment. The practice employs a team of four practice nurses and two healthcare assistants. GPs and nurses are supported by the practice manager, assistant practice manager and a team of reception and administration staff. The practice has not been subject to a previous inspection.

Services are provided from:

Heathcote Medical Centre, Heathcote, Tadworth, Surrey, KT20 5TH.

The practice has opted out of providing out of hours services to their patients. There are arrangements for patients to access care from an out of hours provider by dialling 111.

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 was 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

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Surrey Downs Clinical Commissioning Group (CCG). We carried out an announced visit on 11 November 2014. During our visit we spoke with a range of staff, including GPs, practice nurses, health care assistants (HCAs) and administration staff.

Detailed findings

We observed how patients were being cared for and talked with six patients and reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 18 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, from 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.

We reviewed safety records, incident reports and minutes of meetings from the previous 12 months. These showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months. Significant events were reviewed at significant event meetings and included on the practice team meeting agenda in order to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff, were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Records of significant events and complaints were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, the practice team had been required to administer cardio pulmonary resuscitation to a patient visiting the practice. The team had reflected on how effectively they had worked together to successfully resuscitate the patient. Following the incident, the location of the emergency equipment was highlighted on the practice's patient software system as a regular reminder to staff. The induction checklist for all new staff also included the location of emergency equipment.

National patient safety alerts were disseminated to practice staff and responded to appropriately. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us that alerts were shared and relevant action taken. Alerts received were discussed within the twice weekly clinical forums held within the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a dedicated GP lead for safeguarding vulnerable adults and children. All GPs had received level three training in child protection and we reviewed evidence to confirm this. Nursing staff had level two child protection training and reception and administration staff level one. All staff had received protecting vulnerable adults training appropriate to their role. We spoke with GPs, nurses, healthcare assistants, reception and administration staff about safeguarding. They were able to demonstrate they had received the necessary training to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. Contact details for local authority safeguarding teams were easily accessible within the practice.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This ensured staff were aware of specific actions to take if the patient contacted the practice or when patients attended appointments. For example, older patients with complex care needs, children and families affected by domestic abuse or looked after children.

There was active and appropriate engagement in local safeguarding procedures and collaborative working with local authority teams. One GP we spoke with described how they had raised concerns relating to a young child on the child protection register who failed to attend for a routine baby check. Systems were in place to ensure sharing of information with the local health visitor. Monthly meetings were held with the health visitor to discuss children of concern.

Staff we spoke with demonstrated a good understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. One member of staff we spoke with described an incident which had occurred on the day of our inspection in which they had reported safeguarding concerns to the GP safeguarding lead. Staff described the open culture within

the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding was displayed in the patient waiting room and other information areas.

A chaperone policy was in use within the practice. The policy was on display within the waiting room but was not clearly advertised to patients in the consulting rooms. Chaperone training had been undertaken in May 2014 by some reception staff and the assistant practice manager. However, reception staff undertaking chaperone duties had not been subject to a criminal records check through the Disclosure and Barring Service and the practice had not undertaken a risk assessment to support this decision.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records to confirm this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked at the time of inspection were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate 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. Reviews were undertaken for patients on repeat medicines. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

The practice prescribing lead worked closely in conjunction with the local clinical commissioning group and participated in prescribing audits and reviews. The prescribing lead produced a monthly medicines information update which provided guidance for all GPs and nurses which was accessible to them on the practice computer system.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and that 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.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection.

The practice had a lead nurse for infection control who had received training to enable them to provide advice on the practice infection control policy and to carry out staff training. The lead had recently provided an infection control update for staff within the practice.

The practice had participated in a comprehensive audit of all infection control processes with an external specialist advisor in March 2014. We saw that an infection control action plan had been developed as a result of this audit. Many of the required actions identified within the audit had been completed, such as the siting of blood and body fluid spill kits and the correct labelling of sharps bins prior to and following use. We saw that some recommended actions which were still in the process of being completed had been reviewed. All completed actions and reviews had been clearly recorded. Outstanding actions had been assigned to a team member with responsibility for the action.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

Requires improvement

Are services safe?

The practice had identified the risks associated with potential exposure to legionella bacteria which is found in some water systems but had not taken steps to reduce those risks. A legionella risk assessment had been undertaken by an external organisation in July 2014. However, the practice manager told us that the required actions resulting from the findings of the risk assessment had not yet been responded to. For example, we saw that the risk assessment identified several areas with a high risk rating, such as the temperature of the water in the cold water tank. Required remedial works to rectify those high risk findings had not yet been planned by the practice.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence that relevant medical equipment was calibrated and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. For example, in relation to digital blood pressure machines and weighing scales. However, the practice manager told us that other portable electrical equipment was not routinely tested and we saw no evidence of a risk assessment relating to each piece of equipment to support this decision

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions.

Staffing and recruitment

Staff told us there were 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.

We examined the personnel records of four members of staff and found that appropriate recruitment checks had not always been undertaken prior to employment. For example, the records relating to a nurse who had been recruited as a bank nurse in 2012 and then as a permanent member of staff in June 2013, included no evidence that a criminal records check had been carried out via the Disclosure and Barring Service (DBS). However, a practice nurse recruited in October 2013 had been subject to all required pre-employment checks. The practice had not carried out criminal record checks of reception staff who had been trained to provide chaperone services and who may have been left alone with vulnerable patients.

The practice manager told us that the practice had very recently made the decision to carry out retrospective criminal records checks for their nursing staff. Those application forms were being completed at the time of our inspection but had not been submitted. The practice had not considered applying for criminal records checks for staff trained to act as chaperones. We saw no evidence of risk assessment to support the practice's decisions relating to which roles should be subject to a criminal records check.

Monitoring safety and responding to risk

The practice was located in modern, purpose built premises with good access for disabled patients. We observed the practice environment was organised and tidy. Safety equipment such as fire extinguishers and defibrillators were checked regularly and sited appropriately.

The practice had considered some of the risks of delivering services to patients and staff and had implemented some systems to reduce risks. We reviewed one risk assessment which included a basic assessment of risks associated with health and safety of the environment, such as slips, trips and falls. However, risk assessments had not been carried out in relation to key areas, such as fire safety arrangements. The practice had employed an external contractor to conduct a risk assessment relating to the exposure to legionella bacteria, which is found in some water supplies, in July 2014, but had not taken action in response to the high risk areas identified.

We saw that staff were able to identify and respond to changing risks to patients, including deteriorating health and well-being or medical emergencies. The GPs worked from an unlimited message list which meant that reception staff could arrange for patients to be called back by their named GP the same day or if more urgent, by the duty GP.

For patients with long term conditions, children and those with complex needs, there were processes to ensure they were seen in a timely manner. Staff told us that these patients could be urgently referred to the duty GP and offered urgent appointments when necessary. One patient we spoke with on the day of our inspection told us that urgent same day appointments had always been made available for their children.

Requires improvement

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. 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).

We saw evidence that the practice team had recently been required to administer cardio pulmonary resuscitation to a patient visiting the practice. The team had reflected on how effectively they had worked together to successfully resuscitate the patient. Following the incident, the location of the emergency equipment was highlighted on the practice's patient software system as a regular reminder to staff. The induction checklist for all new staff also included the location of emergency equipment. All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

We saw records showing all GPs and nursing staff had received training in basic life support in 2014. Reception and administration staff within the practice had not received basic life support training since February 2011. The practice manager told us the practice was aware this training was overdue.

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 used to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan had been developed to deal with a range of emergencies that may impact on the daily operation of the practice. Mitigating actions were recorded in order to reduce and manage the risk. 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. Copies of the plans were available in the practice manager's office and the GP partners also held copies off site. Staff we spoke with knew where to locate the plans in the event of an emergency.

The practice manager told us that a fire risk assessment of the practice had not been undertaken. We saw records that showed only four members of staff had undertaken any fire safety training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. 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 registered manager told us they and other GPs in the practice held lead roles in specialist clinical areas such as diabetes, chronic obstructive pulmonary disorder, mental health and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. A practice nurse told us how diabetic patients received care and support under a tier three diabetes care pathway. The nurse worked closely with the GP lead for diabetes and had open access to support from the community diabetic liaison nurse in providing care for diabetic patients. Implementation of the tier three care pathway meant that the practice was able to access support for the most complex diabetic patients via specialist diabetic clinicians based at the local hospital who provided visits to the practice.

GPs and nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, the mental health lead supported all staff to continually review and discuss new best practice guidelines for the management of mental health conditions and dementia. The mental health lead GP had been working with the local clinical commissioning group to develop mental health care pathways and further improve the management of mental health conditions within the practice. The practice provided weekly memory clinics as part of their provision of enhanced services to provide timely diagnosis and support to patients with dementia.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The registered manager told us that GPs used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks.

The practice ensured that patients had their needs assessed and care planned in accordance with best practice. We saw that patients received appropriate treatment and regular review of their condition. Patients with palliative care needs were supported using the Gold Standards Framework. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions.

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

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice had a system for completing clinical audit cycles. The practice showed us clinical audits that had been undertaken in the last year. The GPs told us clinical audits were often linked to safety alerts and NICE guidance. For example, in September 2014 the practice undertook an audit review of patients who were taking a medicine used to treat some cancers and conditions such as rheumatoid arthritis. The medicine could cause serious side effects and required patients to undergo regular blood monitoring. The practice considered NICE guidance and guidance from the British Society for Rheumatology in undertaking the audit. The findings of the audit had resulted in actions to improve patient care and safety, such as a blood monitoring reminder alert every time the notes of a patient taking this medicine were accessed. Examples of other clinical audits undertaken by the practice included a review of patients prescribed antibiotics to treat tonsillitis and a review of the effectiveness of monitoring patients prescribed combined oral contraceptives.

Good

Are services effective?

(for example, treatment is effective)

The practice achieved 99.47% of the maximum Quality and Outcomes Framework (QOF) results 2012/13. QOF is a national performance measurement tool. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF data showed the practice performed well in comparison to the regional and national average. For example, the number of patients diagnosed with dementia whose care had been reviewed within the previous 15 months was recorded as 95.3%, with the national average being 83.2%. The practice was not an outlier for any QOF clinical targets.

The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Twice weekly clinical and educational meetings provided GPs and nurses with the opportunity to regularly review outcomes, new guidance and alerts and for the dissemination of information. Staff spoke positively about the culture in the practice around education, audit and quality improvement, noting that there was an expectation that all GPs and nurses should undertake regular clinical audits. The practice had appointed a lead nurse for education who provided developmental support to the nurse team. This lead nurse was due to undertake a mentorship course to further develop her role and to enable the practice to support nurse training in the future. The practice provided training and support to GP registrars in training and final year medical students on placement within the practice.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that some staff were not up to date with attending mandatory training courses. The majority of administrative and reception staff had not received training in basic life support since February 2011. However, the practice had recently successfully resuscitated a patient and had demonstrated that this delayed training had not had an impact upon their ability to respond to emergency situations. Only four of the staff team had undertaken any fire safety training. All staff had received training in adult and child safeguarding at a level appropriate to their roles.

A good skill mix was noted amongst the GPs. The practice had identified GPs to undertake lead roles in clinical areas such as palliative care, diabetes and mental health. All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. 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 participated in annual appraisals which identified learning needs and generated a personal development plan. We examined records of appraisals and saw that some appraisals for administrative and reception staff did not include documented input from the appraiser. The appraisal record had been written by the staff member themselves and the personal development plan agreed with their line manager. The line manager confirmed that they had been involved in those appraisal reviews and had agreed the personal development plans. A practice nurse told us they last had an appraisal with one of the GP partners in February 2014. This had included a detailed review of performance and the setting of objectives and learning needs. We saw evidence which confirmed this appraisal included detailed and documented input from the appraiser.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We spoke with the education and liaison nurse who told us the practice supported education and ongoing professional development. The nursing team were able to attend additional training in specialist areas such as spirometry, cervical screening and immunisations. Those nurses with extended roles had undertaken advanced training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes. We spoke to a healthcare assistant who told us they felt well supported in their role and had been provided with relevant training. For example, the healthcare assistant was involved in administering flu vaccinations to patients. They had received training to ensure their competence in carrying out those vaccinations. As the practice was a training practice, doctors who were in training saw patients during extended appointments and had access to the GP training lead throughout the day for support.

In response to patient feedback about the unhelpful nature of some reception staff, the practice had developed an ongoing programme of training. The practice manager told us this included customer care training and telephone skills

Good

Are services effective?

(for example, treatment is effective)

training. The practice manager and a GP partner were involved in delivering the training to ensure it was specific to the needs of the practice and to ensure the support of staff involved. The practice had updated their telephone system to enable calls to be monitored in order to further enhance this training.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed ongoing support and helped them plan their care.

For example, the practice demonstrated they had developed effective working relationships with two local residential care homes and a home for patients with learning disabilities. A named GP carried out weekly visits to the homes to conduct ward rounds. Care plans were in place for those patients with complex needs.

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. All relevant staff were clear on their responsibilities for passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. The practice had a policy for communicating with the out of hours service via a system of special notes.

The practice held regular multidisciplinary team meetings to discuss patients with complex needs. For example, those with end of life care or a cancer diagnosis. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The practice worked closely with staff and palliative care nurses at a local hospice to support those patients receiving end of life care. Patients with palliative care needs were supported using the Gold Standards Framework. A community matron also visited the practice on a weekly basis to discuss frail and elderly patients and provide support to the GPs.

GPs in the practice worked closely with the mental health team to refer patients for counselling or cognitive behavioural therapy. The practice lead for mental health and learning disabilities worked closely with the local clinical commissioning group to develop mental health care pathways and further improve the management of mental health conditions within the practice.

The practice hosted a weekly ultrasound service which meant that patients could be referred for ultrasound scan appointments within the practice in a timely manner.

Information sharing

The practice used 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 used to make referrals through the choose and book system. (The choose and book system enabled patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems available to provide staff with the information they needed. An electronic patient record was created within the practice computer software system called EMIS Web and was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. One of the GP partners had participated in a two day user group conference to ensure the effective use of the system within the practice and to support other team members.

Consent to care and treatment

We found that most staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples of how a patient's best interests were taken into account if they did not have capacity to make decisions or understand information.

Patients with more complex needs, those in care homes or with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. Care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, written consent was

Good

Are services effective?

(for example, treatment is effective)

taken for all minor surgical procedures such as joint injections and minor surgical excisions. A patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

Patients who registered with the practice were offered a health check if they were over 40 years of age or had a long term condition for which they required regular medicines. Health checks were also available with a nurse or healthcare assistant to any new patient who requested a check.

We noted a culture amongst the GPs of using their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and opportunistic chlamydia screening to patients aged 18-25.

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriately timed intervals. A dietician and podiatrist regularly provided support to diabetic review clinics in order to further promote the health and wellbeing of this group of patients. The practice provided weekly memory clinics as part of their provision of enhanced services to provide timely diagnosis and support to patients with dementia.

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities, for whom they carried out annual health checks.

The practice offered a full range of immunisations for children, travel vaccines, flu, pneumococcal and shingles vaccinations in line with current national guidance. We reviewed our data and noted that 83% of children aged up to 24 months had received their mumps, measles and rubella vaccination. Data we reviewed showed that 90% of patients with diabetes had a flu vaccination within the six month period between September and March. This was equivalent to the national average.

We noted that a wide range of health promotion information was available in leaflets in the waiting rooms and on the practice website. Such information was also given to patients during consultations and clinics.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were fairly satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 71% of respondents described the overall experience of the practice as good, compared with a national average of 85%. The survey found that 90% of patients said the last nurse they saw was good at treating them with care and concern and 76% of patients felt the GP was good at treating them with care and concern.

We spoke with six patients on the day of inspection and reviewed 18 comment cards completed by patients in the two weeks before the inspection. The comments we reviewed were mostly positive and described the professional, excellent care received by patients. One commented on the unhelpful nature of some reception staff. All of the patients we spoke with on the day of inspection told us that all staff were helpful and professional. They said staff treated them with dignity and respect.

We reviewed the feedback provided about the practice on the NHS Choices website, by 17 patients since November 2013. 15 patients had rated the practice with one star out of a possible five stars. Many of those patients described unhelpful reception services, an inaccessible telephone system and a high turnover of GPs. Two patients gave the practice high ratings and described the professionalism of the practice nurses and the understanding and helpful reception staff. The practice manager had provided the anonymous patients with a direct and comprehensive response to their complaints on the website.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains or screens were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard. An electronic display board in the waiting area displayed patient names in order to call them in for their appointment.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk in a back office which helped keep patient information private. We noted a system had been introduced to allow only one patient at a time to approach the reception desk. This was achieved by the installation of a yellow line marker on the floor in front of the reception desk which encouraged patients waiting to speak to a receptionist to stand back. This minimised the risk of patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained to some degree. Staff also told us that they could take patients to the side of the reception desk or into a quiet room away from the reception desk if more privacy was required.

Care planning and involvement in decisions about care and treatment

Patients told us they had enough time during consultations to ask questions and be involved in decisions about their care and treatment. GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent.

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 73% of patients said the GP was good at involving them in decisions about their care. The survey found that 87% of patients said the last nurse they saw was good at involving them in decisions about their care, compared with a national average of 85%.

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 were given appropriate 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 supported these views.

Good

Are services caring?

We saw evidence of care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website also had the functionality to translate the practice information into approximately eighty different languages.

Patient/carer support to cope emotionally with care and treatment

We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations. The practice had developed a carer's resource display within the waiting area which provided extensive information to support patients and their carers to access support groups. This included a carer's resource file and information pack and information about Action for Carers Surrey, a local support group.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The assistant practice manager told us that they were responsible for processing all referrals to a local community support group for carers. The practice computer system then alerted GPs and nurses if a patient was also a carer.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS Local Area Team (LAT) and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

GPs within the practice held personalised lists which meant that all patients had a named GP. The GPs told us that this enabled a continuity of care and accessibility to appointments with a named GP. The GPs within the practice emphasised the value of their personalised lists in understanding the needs of individual patients. However, patients told us that there was usually a two to three week wait to book a routine appointment with their named GP. Patients told us they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with were generally dissatisfied with the practice telephone system. They told us they were often unable to get through to the practice by phone to make an appointment.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the GP national patient survey and the practice's own survey conducted in March 2014. We reviewed an action plan which had been agreed with the patient participation group in March 2014 and highlighted three main areas for improvement.

The practice had installed a new telephone system in an attempt to improve access by telephone for patients. The number of calls generated, particularly at peak times, was being monitored in order to ensure adequate staffing levels. The system enabled the practice to listen in to calls in order to monitor the quality of responses provided to patients. Patients were able to cancel appointments by selecting an option within the automated system. Although some improvements had been achieved, patients we spoke with continued to report poor access to the practice by telephone.

The practice had taken steps to improve access to appointments by expansion of the online appointments system. In addition, one GP partner was in the process of conducting an audit of appointments to determine the effectiveness of the current system in meeting patient needs. They told us that the introduction of a morning triage system was being considered to ensure all patients requesting an urgent appointment were effectively assessed.

In response to patient feedback about the unhelpful nature of some reception staff, the practice had developed an ongoing programme of training. The practice manager told us this included customer care training and telephone skills training. The practice manager and a GP partner were involved in delivering the training to ensure it was specific to the needs of the practice and to ensure the support of staff involved. The practice's updated telephone system enabled calls to be monitored in order to further enhance this training.

Longer appointments were available for patients who needed them and for those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those individual patients who needed a visit. The practice provided care and treatment for patients within a local home for those with learning disabilities. They had a dedicated GP to ensure continuity of care, which was essential for these patients.

Families with children and young people were well supported by the practice. Urgent same day appointments were made available for children throughout the day with the practice's duty GP.

New mothers were supported by a midwife who provided a weekly clinic at the practice. The midwife had a shared care arrangement with the GPs, with antenatal care being primarily provided by the midwife and postnatal care provided by the GP. Baby packs were sent out automatically to a new mother following the birth of a baby. These included an 8 week postnatal check appointment and a form to register the new baby with the practice. A health visitor clinic was held weekly within the practice. The health visitor carried out regular baby checks and liaised with GPs and secondary care teams.

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.

Working age patients were able to book appointments and order repeat prescriptions on line. All GPs within the

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

practice ran an unlimited message list each day. This meant that working age patients were assured that they could speak with a GP to discuss urgent concerns during the day.

Patients experiencing poor mental health were well supported by the practice. The practice had a lead GP for mental health who supported all staff to continually review and discuss new best practice guidelines for the management of mental health conditions and dementia. The mental health lead GP had been working with the local clinical commissioning group to develop mental health care pathways and further improve the management of mental health conditions within the practice. The practice provided weekly memory clinics as part of their provision of enhanced services to provide timely diagnosis and support to patients with dementia. The GPs were able to refer patients to local counselling services and the 'Improving Access to Psychological Therapies' team.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were well supported.

The practice was located in purpose built premises. The premises and services had been adapted to meet the needs of patients with disabilities. Access to the premises by patients with a disability was supported by an automatic door and accessible front reception desk which had been installed with wheelchair users in mind. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. We noted there were car parking spaces for patients with a disability.

Toilet facilities were accessible for all patients and contained grab rails for those with limited mobility and an emergency pull cord. Baby changing facilities were available for mothers with young babies.

The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required. The practice website also had the functionality to translate the practice information into approximately eighty different languages.

Access to the service

The practice operated a flexible appointment system to ensure patients who needed to be seen the same day were accommodated. Appointments were available in a variety of formats including pre-bookable appointments, a telephone triage system and a daily 'duty doctor' system. These ensured patients were able to access urgent healthcare when they needed to.

The practice was open from 8am to 6.30pm on weekdays. Telephone lines were open daily from 8.30am to 12.45pm and from 2pm to 6.00pm. Telephone lines were closed each day between 12:45pm and 2.00pm. The practice provided late evening appointments from 6.30pm – 8.30pm on two evenings each week and Saturday morning appointments were available from 9am-11am.

Comments received from patients showed that those in urgent need of treatment had been able to make appointments on the same day of contacting the practice. One patient we spoke with told us how they often needed an urgent appointment due to a specific medical condition and they were always seen on the same day. We also spoke to a mother who had brought her child to the practice for an urgent appointment. The mother told us that she had always been able to access urgent same day appointments when required for her children.

Patients told us that there was usually a two to three week wait to book a routine appointment with their named GP. Patients told us they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with were generally dissatisfied with the practice telephone system. They told us they were often unable to get through to the practice by phone to make an appointment.

Of the patients who responded to the GP national survey only 41% of patients found it easy to get through to the practice on the phone, compared with a national average of 75%. The percentage of patients who were very satisfied or fairly satisfied with the opening hours of the practice was 61% compared with a national average of 79%.

The practice had conducted its own patient survey in March 2014 and had agreed resulting actions with the patient participation group. Actions to improve access to appointments had included extending access to online appointment bookings and allowing patients to book follow up appointments more than two weeks in advance. A new telephone system had been installed which had improved access to some degree. However, patients still reported delays and difficulties in getting through to the practice.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

There were arrangements 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 on the website, practice leaflet and appointment information advertised in the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent and routine appointments, telephone consultations and home visits and how to book appointments through the website.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were posters in the waiting rooms to describe the process should a patient wish to make a compliment, suggestion or complaint. Information was also advertised in the practice leaflet and 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 made a complaint about the practice.

We looked at the complaints log for those received in the last twelve months and found these were all discussed, reviewed and learning points were noted. Complaints were discussed at clinical meetings, partners meetings and practice team meetings. The practice reviewed complaints on an annual basis to detect themes or trends. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

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. The practice was clinically well led with a core ethos to deliver the best quality clinical care whilst maintaining a high level of continuity.

We spoke with 13 members of staff and they all knew and understood the vision and values and were clear about what their responsibilities were in relation to these.

Governance arrangements

The practice had developed a number of policies and procedures and these were available to staff via the desktop on any computer within the practice. We reviewed a selection of policies and procedures and these had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and another lead nurse for education. There were also lead GP roles for safeguarding, diabetes and mental health. We spoke with 13 staff members and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

Twice weekly clinical and educational meetings provided GPs and nurses with the opportunity to regularly review outcomes, new guidance and alerts and for the dissemination of information. Regular nurse team meetings provided the opportunity for the nursing team to share learning and review their practice. Staff spoke positively about the culture in the practice around education, audit and quality improvement, noting that there was an expectation that all GPs and nurses should undertake regular clinical audits.

The practice implemented an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw that clinical audits had been undertaken to review patients prescribed antibiotics to treat tonsillitis and to review the effectiveness of monitoring patients prescribed combined oral contraceptives.

Significant events were shared with the practice team to ensure lessons were learned and to prevent reoccurrence. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses

The practice had not ensured that all risks within the practice had been assessed, identified and minimised. For example, the practice had not undertaken a risk assessment of fire safety and evacuation procedures. The practice had identified the risks associated with potential exposure to legionella bacteria which is found in some water systems but had not taken steps to reduce those risks. Chaperone training had been undertaken in May 2014 by some reception staff and the assistant practice manager. However, reception staff undertaking chaperone duties had not been subject to a criminal records check via the Disclosure and Barring Service and the practice had not undertaken a risk assessment to support this decision.

Leadership, openness and transparency

GPs and staff told us about the clear leadership structure and which members of staff held lead roles. For example, there was a lead nurse for infection control and one GP partner was the lead for safeguarding. We spoke with 13 members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw evidence that the practice held regular clinical team meetings, whole practice meetings and partners meetings. We saw that information was shared between the different meetings to ensure that all staff were fully updated. Where appropriate, whole team meeting minutes were posted on a staff notice board to ensure staff who had been unable to attend had access to them. The practice manager ran a system of internal memos to update staff in between team meetings. Copies of the memos were held in a central file for all staff to access as required. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Administration and reception staff told us that they also met within their teams. They explained that when they were unable to attend their manager ensured that

Are services well-led?

Requires improvement

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

minutes of the meetings were circulated. All of the staff we spoke with reported that communication was good in the practice and they were always made aware of new developments and changes.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies to support and guide staff. These were reviewed regularly and up to date. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, a suggestion box and compliments and complaints received. We looked at the results of the annual practice patient survey from 2014 and the corresponding action plan. The results of the survey and the action plan were displayed on the practice website.

The practice had a small patient participation group (PPG) and used the group to seek feedback about new developments or service changes. The group contained representatives from various population groups, including older patients. We spoke with one member of the PPG who told us the practice manager met with the group on a quarterly basis. We saw evidence that the group had met with the practice manager in March 2014 to discuss the findings of the patient survey. As a result of the meeting, an action plan was agreed to support the changes required in response to the feedback gathered.

The practice had installed a new telephone system in an attempt to improve access by telephone for patients. The number of calls generated, particularly at peak times, was being monitored in order to ensure adequate staffing levels. The system enabled the practice to listen in to calls in order to monitor the quality of responses provided to patients. Patients were able to cancel appointments by selecting an option within the automated system. Although some improvements had been achieved, patients we spoke with continued to report poor access to the practice by telephone.

The practice had taken steps to improve access to appointments by expansion of the online appointments system. In addition, one GP partner was in the process of conducting an audit of appointments to determine the effectiveness of the current system in meeting patient needs. They told us that the introduction of a morning triage system was being considered to ensure all patients requesting an urgent appointment were effectively assessed.

In response to patient feedback about the unhelpful nature of some reception staff, the practice had developed an ongoing programme of training. The practice manager told us this included customer care training and telephone skills training. The practice manager and a GP partner were involved in delivering the training to ensure it was specific to the needs of the practice and to ensure the support of staff involved. The practice's updated telephone system enabled calls to be monitored in order to further enhance this training.

A suggestions, compliments and complaints box was held in reception. The practice manager told us that patients were invited to provide positive feedback about staff in order to maintain good levels of staff morale. Nominated staff were then selected to be part of a monthly draw to receive a gift voucher.

The practice had gathered feedback from staff through staff meetings, discussions and surveys. Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We spoke with 13 staff and they confirmed they participated in regular appraisals which identified their training and personal development needs. Staff told us that the practice was very supportive of training and education.

Nursing staff reported that training was available in order for them to maintain and update their skills and they were well supported to attend training events. The practice had appointed a lead nurse for education who provided developmental support to the nurse team. This nurse was due to undertake a mentorship course to further develop

Are services well-led?

Requires improvement

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

her role and to enable the practice to support nurse training in the future. The practice provided training and support to GP registrars in training and final year medical students on placement within the practice. One of the GP partners supervised the trainee doctors at all times.

The practice had completed reviews of significant events and other incidents. These were shared with staff via meetings to ensure the practice improved outcomes for patients. For example, the practice team had been required to administer cardio pulmonary resuscitation to a patient visiting the practice. The team had reflected on how effectively they had worked together to successfully resuscitate the patient. Following the incident, the location of the emergency equipment was highlighted on the practice's patient software system as a regular reminder to staff. The induction checklist for all new staff also included the location of emergency equipment.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **How the regulation was not being met: The provider failed to ensure effective systems were in place to identify, assess and manage risks relating to the health, welfare and safety of service users and others.** **Regulation 10 (1) (b) (2).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **How the regulation was not being met: The provider failed to ensure that patients and staff were protected against the risk of infection from legionella bacteria which is found in some water systems.** **Regulation 12 (1) (a) (b) (c) (2) (a) (c) (i)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **How the regulation was not being met: The provider failed to ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying out the regulated activity, and such other information as appropriate.** **Regulation 21 (b).**

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

How the regulation was not being met: The provider failed to ensure that persons employed for the purposes of carrying out the regulated activity received appropriate training.

Regulation 23 (1) (a)