

East Horsley Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good	
Are services safe?	Good	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

East Horsley Medical Centre was inspected on the 16 October 2014 as a comprehensive inspection.

We have rated the practice as good. The inspection team spoke with staff and patients and reviewed policies and procedures which were in date and relevant. Patient care was reviewed and care plans were in place for patients with complex needs. We noted meetings with other services were in place and the practice shared relevant information with other services in order to provide appropriate care and support. Safeguarding of children and vulnerable adults was understood and taken seriously by the practice, although we noted that not all staff had received relevant training. There was an involvement of patients through the patient participation group. The practice had an ethos of providing good patient care. Training that the practice required staff to complete yearly was not always up to date.

Our key findings were as follows:

- An active patient participation group working in partnership with the practice.
- CQC received 46 comment cards completed by patients all with positive feedback.
- Infection control audits and cleaning schedules were in place and the practice was seen to be clean and tidy.
- The practice had systems to keep patients safe including safeguarding procedures and means of sharing information about patients who were vulnerable.
- Patients' needs were assessed and care was planned and delivered in line with current legislation.

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

Importantly, the provider must:

- The practice must ensure that yearly mandatory training for staff is completed and monitored to ensure

Summary of findings

that time frames for renewal do not lapse. This includes ensuring staff have completed relevant training for safeguarding children and vulnerable adults.

We have issued a compliance action regarding the regulation to support staff.

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 good for safe.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. The practice had safeguarding policies and procedures in place to protect children and vulnerable adults. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency.

Good



Are services effective?

The practice is rated as requires improvement for effective.

Staff had received some training appropriate to their roles however further training needs were identified, including adult safeguarding, resuscitation and equality and diversity. Data showed patient outcomes were at or above average for the locality. National guidance was reflected in patient care and treatment. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice appraised staff on an annual basis. Multidisciplinary working was established and the practice worked closely with other services.

Requires improvement



Are services caring?

The practice is rated as good for caring.

Data showed patients rated the practice as average or 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. Patients had access to local groups for additional support. 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.

The practice reviewed the needs of their local population. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. The practice had good

Good



Summary of findings

facilities and was well equipped to treat patients and meet their needs. 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 within the practice and externally with other key stakeholders.

Are services well-led?

The practice is rated as good for well-led.

The practice had a clear vision in how it delivered care and support to its patients. Staff were involved in writing the practice mission statement. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

Good



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 good for the care of older patients. All patients over 75 had a named GP and those at risk of hospital admissions received a letter detailing the name of their GP, care co-ordinator and were given an emergency by-pass phone number to contact the practice. This enabled emergency calls from this patient group to be answered quickly and consequently to be put through to the relevant GP. 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. Care plans were in place and reviewed every three months for at risk patients. The practice had systems in place to follow up on patients who had attended accident and emergency. The practice was responsive to the needs of older patients, including offering home visits and rapid access appointments for those with enhanced needs.

Good



People with long term conditions

The practice is rated as good for the population group of patients with long term conditions. When needed longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medicine needs were being met. GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care. We saw patients were supported to manage their conditions and could access clinics for support. For example, diabetic clinics which included the dietitian and respiratory services. Patients who were prescribed blood thinning products could attend regular blood test clinics which measured whether or not the dose was correct. Home visits were also offered to patients for this test.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young patients. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Specific services for this group of patients included twice weekly well women clinics, neonatal checks, weekly baby clinics and childhood immunisation clinics including flu immunisation for two-four year olds.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the population group of the working-age patients (including those recently retired and students). Patients could book appointments either by telephoning, in person or on line via the practice's website. This enabled patients to book appointments with the practice at times and in ways that were convenient to them. Patients reported that access was good. Patients were able to request a GP to telephone them instead of attending the practice. 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.

People whose circumstances may make them vulnerable

Good



The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. 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. The practice had good access for those with limited mobility or who used wheelchairs. The practice supported patients who were registered as a carer. The practice advertised other services that could provide support for this population group.

The practice was aware of its patients with learning disabilities and had a lead GP. However, we were told that this group of patients did not currently have care plans in place. The lead GP was in the process of reviewing patient records with a learning disability and ensuring that annual health checks had taken place and if not were inviting patients to attend.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the population group of patients experiencing poor mental health (including patients with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. Some of the staff had received training on dementia and this included nurses and receptionists. Consultants and psychologists had been invited as guest speakers at meetings. Patients could access mental wellbeing counsellors who were based at the practice twice a week. The practice was proactive at recognising patients who were at risk of dementia and were using questionnaires to aid screening.

Summary of findings

What people who use the service say

Patients told us they were satisfied with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 46 comment cards which contained positive comments about the practice. We also spoke with nine patients on the day of the inspection.

All the patients we spoke with were positive about the service they received. They told us it was fairly easy to contact the practice and make appointments. They told us that staff were friendly and helpful.

Comments received through the comments cards were positive about the service patients received. We received a few comments that patients had to wait to see the GP of

their choice but most told us that appointments were readily available. Comments about the practice included that patients felt listened to, supported and were treated with dignity and respect. Comments also highlighted that staff were attentive, kind and caring.

We viewed the results for the patient survey completed in 2014 by the patient participation group. The practice had received a response from 549 patients to this survey. The findings indicated that

98% of patients were satisfied or very satisfied with the care they received. The findings also indicated that

89% of patients would recommend the practice to friends or family.

Areas for improvement

Action the service **MUST** take to improve

- The practice must ensure that yearly mandatory training for staff is completed and monitored to ensure

that time frames for renewal do not lapse. This includes ensuring staff have completed relevant training for safeguarding children and vulnerable adults.

East Horsley Medical Centre

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 second CQC inspector, a GP and a practice manager.

Background to East Horsley Medical Centre

The practice is located in a residential area of Leatherhead and provides a range of primary medical services to approximately 10,000 patients. The practice covers the parishes of East and West Horsley, East and West Clandon, Effingham, Little Bookham, Ockham and parts of Ripley.

The practice has two partner GPs registered with CQC and a further GP in the process of being registered, as well as five salaried GPs. There is a mix of both female and male GPs. The practice is open 8.30am till 6.30pm. There is an open surgery each morning from 8:30am. Appointments may be booked up to a month in advance and every day there are several appointments made available for each GP. The practice runs an “extras” surgery each morning at 11:30am; these consultations are shorter than routine appointments. Each afternoon a few appointments are reserved for emergencies.

The practice also employs a nurse practitioner, five practice nurses and a healthcare assistant / phlebotomist. GPs and nurses were supported by a practice manager and business manager as well as a team of 17 administration staff.

The practice runs a number of clinics for its patients which include child development, immunisations, diabetic, anti-coagulants and well women clinics.

We visited the practice location at Horsley Medical Practice, The Medical Centre, Kingston Avenue, East Horsley, KT24 6QT

The practice had opted out of providing Out of Hours services to their own patients. There were arrangements in place for patients to access emergency care from an Out of Hours provider.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. 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.

How we carried out this inspection

Prior to the inspection we contacted the local clinical commissioning group, NHS England local area team and the local Health watch to seek their feedback about the service provided by East Horsley Medical Centre. We also spent time reviewing information that we hold about this practice. 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.

The inspection team carried out an announced visit on 16 October 2014. We spoke with nine patients and 15

Detailed findings

members of staff. This included the practice manager, four GPs, three practice nurses, the nurse practitioner, phlebotomist and five reception staff. We also reviewed 46 comment cards from patients and spoke with two members of the patient participation group.

As part of the inspection we looked at the management of records, policies and procedures, and we observed how staff cared for patients and talked with them.

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

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

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

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

The practice had a slightly higher than average percentage of registered patients less than 18 years of age than the average for England. The percentage of registered patients aged over 65 years was higher than the average for England. The percentage of registered patients suffering deprivation (affecting both adults and children) was significantly lower than the average for England.

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 to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, an entry was logged regarding a fridge used to store medicines being accidentally turned off. The practice was able to establish how long the fridge had been turned off and called the drug companies to check the protocol for the individual medicines. We noted during our inspection the plugs to the fridges were now fitted with a safety cover which meant the same incident was unlikely to happen again.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Significant events, incidents and accidents were discussed at the GP daily meetings and monthly practice meetings. Opportunities for all staff to talk to senior members of staff were made available each afternoon during a formal break and staff told us they could use this opportunity to discuss any concerns. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at meetings and felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to practice staff. All safety alerts were printed and kept in a folder within the practice manager's office. The folder was prefaced with a one page guidance document advising how to manage the process. The practice manager distributed the alert to the relevant staff members who needed to sign and date to show that the alert had been read. If the alert was medicine related the

practice analysed their patient population to see if any of the patients were affected by the alert. The duty doctor would review each patient and evidence what action they had taken.

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 most staff had received relevant role specific training on safeguarding children. However, training for safeguarding adults had not been completed by all staff. Staff we spoke with knew how to recognise signs of abuse in older patients, 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.

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 to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and visible in consulting rooms. Nursing staff were trained as chaperones and understood their responsibilities. The practice only allowed staff who had had a criminal record check through the Disclosure and Barring Service (DBS) to act as chaperones.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called EMIS which collated all communications about the patient including scanned copies of communications from hospitals. 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. For example children subject to child protection plans.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

Are services safe?

clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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. The health care assistant also administered vaccines under direction which had been reviewed and approved in line with national guidance and legal requirements. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updated training in the specific clinical areas of expertise for which they prescribed.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. 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 patient's repeat prescriptions were still appropriate and necessary.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. 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 had a lead for infection control. We saw evidence the practice had carried out infection control audits and that any improvements identified for action were completed on time. We reviewed the practice's database for training and noted that most staff had not received up to date training for infection control.

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. Policies included information regarding needle stick injuries and bodily fluid spillages. We noted personal protective equipment including disposable gloves, aprons and coverings were available for staff to use in treatment rooms.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with liquid soap and hand towel dispensers were available in 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 reviewed 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. There was evidence of calibration of all relevant equipment. The practice had two 24 hour blood pressure monitoring machines which were loaned to patients to monitor their blood pressure over a 24 hour period. Staff we spoke with told us this helped patients to understand their blood pressure readings during a normal day, rather than just when attending the practice.

Staffing & Recruitment

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

The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and available for annual leave and sickness absence cover. 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.

Monitoring Safety & 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. These included annual checks of the

Are services safe?

building, equipment, fire safety and dealing with emergencies. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the identified health and safety lead.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions including giving patients a by-pass number to the practice. This enabled emergency calls from this patient group to be answered quickly and consequently to be put through to the relevant GP. GP's also explained emergency processes which were in place for acute pregnancy complications.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing most staff had received training in basic life support. Emergency

medicines and equipment were available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records confirmed these were checked regularly. 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 identified included power failure, adverse weather, unplanned sickness and access to the building. For example, we noted that in adverse weather conditions some staff were able to walk to the practice and there was use of a 4x4 to provide emergency home visits to patients if required.

A fire risk assessment had been undertaken date with fire training. All staff we spoke with were aware of their responsibilities in the event of a fire and were able to describe their training to us. For example, staff had been taught and had practiced using fire equipment.

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 the way that they delivered treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We reviewed minutes of meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcomes 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.

Patients had their needs assessed and care planned in accordance with best practice. A review of 12 case notes for patients showed that all were on appropriate treatment and had regular reviews. The practice used computerised tools to identify patient groups who were on registers. For example, carers, patients with learning disabilities or with long term conditions. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

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.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. An examples of a clinical audit included reviewing patients who had a blood test within three months of being prescribed a particular medicine. We noted that two audits had taken place in both 2013 and 2014 with the results of those not attending for their blood tests being at a similarly low rate. We noted the practice

had reminded staff that monitoring of these patients was required and that further prescriptions for the medicines should be halted until the required blood test had been done.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. This practice was not an outlier for any QOF (or other national) clinical targets. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. The practice achieved 94.5% of the maximum Quality and Outcomes Framework (QOF) results 2012/13 in the clinical domain. For example, the percentage of patients diagnosed with dementia whose care had been reviewed in the previous 15 months was recorded as 90.7%, with the national average being 83.2%

GPs we spoke with informed us that patients with learning disabilities did not currently have care plans. However, there was a lead GP for this group of patients. They were responsible for checking patient records to ensure that an annual health check had taken place and if it had not they were inviting patients to attend.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice manager provided us with a spread sheet which recorded staff mandatory training. This indicated that staff training was not up to date. We saw that from 19 administration staff, including the practice manager and business manager, only seven staff had up to date training for resuscitation (basic life support). No administration staff had received training on adult safeguarding and records showed that only five administration staff members had received equality and diversity training. Ten administration staff had not received fire training, no administration staff had received training in infection control and nine had not received training for information governance. Records also indicated that nursing staff were not up to date with training. For example, four out of eight nurses did not have a date recorded for infection control training and two had no date for resuscitation training or safeguarding children.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is

Are services effective?

(for example, treatment is effective)

appraised annually and every five years undertakes a fuller 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).

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 and wound care. Those with extended roles, for example seeing patients using blood thinning products and needing blood testing, were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice followed the Gold Standard Framework for palliative care patients. The practice worked with other service providers to meet patient's needs and manage complex cases. The practice held multidisciplinary team meetings every three months to discuss the needs of patients with complex needs. For example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and a member of staff from the local hospice as appropriate. Decisions about care planning were documented.

The practice had dedicated rooms available for counsellors, health visitors and the community matron on site. Community matrons are highly experienced senior nurses who work closely with patients in the community to provide, plan and organise their care. Staff told us this allowed for efficient and faster communication. Midwives also visited the practice on a weekly basis, as well as a visiting physiotherapist.

Blood test results, X ray results, letters from the local hospital including discharge summaries and Out of Hours providers were received both electronically and by post. Staff were aware of their responsibilities in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. Patients were registered to a GP and the relevant GP was responsible for over-seeing these communications and any actions required. A daily discharge summary was printed and reviewed at the GPs morning meeting. Patients over 65 were phoned if they had attended accident and emergency to ensure that they had the required support they needed or if necessary a GP visit or a medicines review. Any patients who had attended

Accident and Emergency more than three times were identified and care plans put in place if required. The practice had a system of referrals letters being reviewed and signed at the GP morning meetings. Staff told us that the meetings ensured that referrals discussed were appropriate and were turned around within 48 hours.

Information Sharing

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

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.

Consent to care and treatment

Patients we spoke with told us that GPs always obtained consent before any examination took place.

The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The policy also gave guidance about withdrawal of consent by a patient. A form was available to record consent where appropriate. Gillick competencies was also referred to in the policy. Gillick competencies help GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment.

The practice had a Mental Capacity Policy. The policy gave staff guidance on the core principals of the Mental Capacity Act 2005 and also contained an assessment of capacity checklist for staff to use if required. The policy also detailed the actions the practice would complete in order to help patients make decisions for themselves. This included providing relevant information in a way the patient would understand.

Patients with dementia were supported to make decisions through the use of care plans which they were involved in

Are services effective?

(for example, treatment is effective)

agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. 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. 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 appropriate timed intervals.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. We reviewed our data and noted that 79% of patients aged 65 and over had received a seasonal flu vaccination and 79% of women aged between 25 and had received a cervical screening test in the last 5 years.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and on the practice website. The practice booklet included information on social services and voluntary organisations for patient reference.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received 46 completed cards and all were positive about the service experienced.

Patients said they felt the practice offered a good service and staff were helpful and caring. They said staff treated them with dignity and respect. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 549 patients undertaken by the practice's patient participation group. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with GPs and nurses with 96% of practice respondents saying the GP was good at listening to them and 94% saying the GP gave them enough time. 98% of patients surveyed by the patient participation group said they were satisfied or very satisfied with the care received at the medical centre.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff followed the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The reception team was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, low music was played in the waiting room areas to prevent patients overhearing potentially private conversations between patients and reception staff. We

noted a system had been introduced to allow only one patient at a time to approach the reception desk. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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 88% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. However, both these results were slightly below the national average.

Patients we spoke to 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.

CQC GP specialist advisor reviewed 12 patient records. Patient records with long term conditions contained care plans which were well recorded and evidenced patient involvement. GPs we spoke with told us of the various ways they supported patients to understand conditions and treatments. This included using diagrams or printing information that patients could read at home.

Patient/carers support to cope emotionally with care and treatment

Notices and leaflets in the patient waiting room, and practice website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Information for carers was available at the reception desk to ensure they understood the various avenues of support available to them.

Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed.

The practice was part of a carer recognition service provided by a county wide agency. The practice was able to

Are services caring?

put forward patients, who were carers, who could benefit from additional financial support. We saw thank you cards from patients to the practice that had been supported through this service.

We noted in the significant events log an entry indicating a patient had delayed their own treatment as they were caring for a relative. The practice had recognised the difficulty this patient had in attending appointments and had requested additional support from a local charity.

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 patient's 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.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and 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 patients who needed one.

The practice had two blood pressure monitoring machines which were loaned to patients to monitor their blood pressure over a 24 hour period. Staff we spoke with told us this helped patients to understand their blood pressure readings during a normal day, rather than just when attending the practice.

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, the PPG had completed a patient survey in July 2014 with 549 patients responding. The results were discussed with the practice including comments regarding patient confidentiality in the waiting room. This had been addressed by the practice and there was now a line for patients to wait behind before booking in with the receptionists. We also found low level music was played in the waiting room to help with patients not being overheard whilst booking in.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services. The practice's computer system alerted GPs to those patients that might be deaf or partially sighted and the GPs would collect patients from the waiting room to assist them to the consulting room.

The practice website could be translated into over 50 languages and the website had the facility to change the size of displayed text for partially sighted patients.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice was situated on two floors with all services for patients taking place on the ground floor. There were automatic opening doors for patients into the practice foyer and the waiting room. The waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toilet facilities were available for all patients including baby changing facilities. One toilet contained grab rails for those with limited mobility and an emergency pull cord.

Access to the service

Appointments were available from 8.30am till 6pm on weekdays. Patients could call to make appointments from 8am and there were on line facilities for patients to book appointment at times convenient to them. A sit and wait surgery was available each morning from 8.30am and GP morning surgeries were from 8.40am till 11am. From 11.30am to 12.30pm the practice offered five minute appointments. Home visits and booked slots were available from 2.45pm until 3.45pm. Afternoon surgery started at 3pm until 6:30pm. Appointments could be booked on the day or up to one month in advance. Emergency appointments were available throughout the day.

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. Patients were also given information through an appointment system leaflet. There were 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.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & complaints

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

Information was available to help patients understand the complaints system. The practice website had details explaining the process and we noted there was a complaints procedure leaflet available for patients. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last twelve months and found these were dealt with in a timely manner and a full investigation was completed. Information reviewed showed that the practice took complaints seriously and where necessary changed the way practice worked in order to learn from them. For example, the practice had received a complaint regarding clinic times for the children's flu vaccination. We noted the practice had taken the complaint seriously and added an extra evening clinic.

Are services well-led?

Good 

(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 values were part of the practice's mission statement. The practice mission statement included the statement to provide a professional, caring and supportive personalised service for patients with respect, confidence and compassion.

We spoke with 15 members of staff who echoed the practice values. They told us they thought they provided a professional and caring service. We looked at minutes of the staff meeting held in August 2014 where staff had discussed the mission statement.

Governance Arrangements

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. These had also been printed for staff convenience. We looked at some of these policies and procedures and staff had completed a cover sheet to confirm they had read the policy and when. This included the whistleblowing policy, complaints policy, health and safety, confidentiality, information governance and infection control.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards. The practice had completed a number of clinical audits. For example, an audits for patients receiving medication for rheumatoid arthritis and required blood tests.

Patient participation group (PPG) members we spoke with were very complimentary about the involvement they had in decisions about the running of the practice.

Leadership, openness and transparency

The practice had a leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and senior partners were the leads for safeguarding. We spoke with 15 members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly. 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. Meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. We reviewed minutes of the partner meetings, staff meetings, nursing meetings and meetings with the patient participation group. We found that performance, quality and risks had been discussed. Significant events and complaints were shared with the practice team to ensure they learnt from them and received advice on how to avoid similar incidents in the future.

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

The practice used a number of mechanisms to encourage and obtain patient feedback. This included, through the patient participation group (PPG), through the national GP patient survey and a comments box at the reception desk.

We met representatives from the PPG. The PPG had a core group who met regularly and their meetings were attended by a practice partner and the practice manager. They informed us that the PPG and practice were working in partnership to tackle comments raised during their patient survey as well as information received from the local clinical commissioning group (CCG). They told us that partners and staff at the practice were very approachable and felt included in helping to improve patient care.

The PPG conducted a survey over four days and ensured that representatives from various population groups were asked to participate. We were shown the analysis of the survey of which 549 patients had responded. The results of the survey had been discussed with the practice and an action plan created. Actions agreed from this survey were available for patients to review on the practice website.

Staff told us they would not hesitate 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.

Management lead through learning & improvement

The practice manager appraised all administration staff on an annual basis. Staff told us they felt the appraisal was a

Are services well-led?

Good 

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

meaningful process which allowed for open discussions. The nurse practitioner informed us there were plans to increase their role which would include running a minor illnesses clinic and completing medicine reviews. They told us they felt supported by the practice to achieve this.

The practice completed reviews of significant events and other incidents and shared the learning with the staff team to ensure the practice learnt from incidents to improve outcomes for patients. Staff told us changes to protocols and policies were made as a result of learning outcomes from significant events, national guidance and audits. For example, after a computer system crash, a list of passwords and server programmes had been produced and information added to 'How do I' folder for staff to reference in the event of it happening again.

Training for all practice staffing, included, GPs, nursing, managerial and administrative staff were not always up to date. The practice manager provided us with a spread sheet which recorded training which the practice expected staff to complete yearly. This indicated that staff training was not up to date. We saw that not all staff had completed training in resuscitation (basic life support), adult safeguarding, equality and diversity, fire training, infection control and information governance. We spoke with the practice manager in relation to this, who was aware that training was not up to date. The practice manager was able to explain future plans to review how training would be recorded and monitored to ensure staff training would always be up to date.

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	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: Suitable arrangements were not in place for staff to receive appropriate training. Regulation 23 (1) (a)
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	