Dr Evans and Partners

Quality Report

Fairfield Medical Centre,
Lower Road,
Great Bookham,
Leatherhead,
Surrey,
KT23 4DH
Tel: 01372 455450
Website: www.fairfieldmedicalcentre.co.uk

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Evans and Partners (also known as Fairfield Medical Centre) on 12 May 2015. Overall the practice is rated as good.

Dr Evans and Partners provides personal medical services to people living in the Leatherhead area. At the time of our inspection there were approximately 10,500 patients registered at the practice with a team of five GP partners. The practice was also supported by salaried GPs, GPs in training, a practice nurse, phlebotomist, a team of reception and administrative staff, an assistant practice manager and a practice manager

We visited the practice location at Fairfield Medical Centre**,** Lower Road, Great Bookham, Leatherhead, Surrey, KT23 4DH.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice and staff told us they felt supported. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings were as follows:

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, reviewed and addressed.
- Risks to patients were assessed and well managed
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients told us they did not always find it easy to make an appointment or have appointments with their named GP however they had been able to access urgent appointments on the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly, the provider must:

- Ensure that all recruitment checks are carried out and recorded as part of the staff recruitment process. Ensure there is a written risk assessment where decisions have been made regarding staff not receiving a criminal record check via the Disclosure and Barring Services (DBS)
- Ensure that an infection control audit is completed on a regular basis and any actions recorded and updated. Complete a risk assessment for the control of substances hazardous to health (COSHH) and ensure that a risk assessment for legionella is completed.

In addition the provider should:

- Ensure that complaints information is clearly displayed.
- Improve the quality of record keeping to ensure that actions from significant events are clearly evidenced.
- Ensure there is a readily available business continuity plan for staff to follow.
- Ensure that staff have a date for outstanding appraisals.
- Continue to review and implement improvements to patients' access to the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Audits, significant events and complaints were reviewed and learning discussed with clinical staff. Although risks to patients who used services were assessed, the systems and processes to address these risks were not always implemented well enough to ensure patients were kept safe. For example, all recruitment checks required were not documented, the practice were unable to locate records of infection control audits, there was no system in place for the management of legionella and there was no business continuity policy in place for the continued running of the service in the event of an emergency. Staff told us they routinely asked if patients would like a chaperone for intimate examinations and we saw information on display offering this service. Emergency procedures were in place to respond to medical emergencies. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with local multidisciplinary teams to provide patient centred care.

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

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England area team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients told us they did not always find it easy to make an appointment with a named GP however they had been able to access urgent appointments on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and worked closely with the practice. Staff had received inductions and attended staff meetings and events. We noted that most staff had received regular performance reviews however due to a change in senior staff management some administration staff were overdue their yearly review.

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

Good

The practice is rated as good for the care of older people. Patients had a named GP which allowed for continuity of care. 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. Elderly patients with complex care needs all had personalised care plans that were shared with local organisations to facilitate the continuity of care. The practice was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. The GPs followed national guidance for reviewing all aspects of a patient's long term health. 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. The practice nurse was trained and experienced to support patients with managing their conditions and preventing deterioration in their health. The practice had plans to start a specialist clinic with the support of a GP who would lead for diabetes and a specialist nurse from the clinical commissioning group (CCG) for those patients with more complex diabetes management.Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

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 was suitable for children and babies. Patients told us that children and young people were treated

Summary of findings

in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered coil fitting and contraceptive implants. Practice staff had received safeguarding training relevant to their role. Safeguarding policies and procedures were readily available to staff. All staff were aware of child safeguarding and how to respond if they suspected abuse. The practice ensured that children needing emergency appointments would be seen on the day.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered NHS health-checks and advice for diet and weight reduction. Smoking cessation advice was offered and patients could request routine travel immunisations.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those who were housebound or with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. It offered longer appointments for patients when required. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. Carers and those patients who had carers were flagged on the practice computer system and were signposted to the local carers support team.

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People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients with severe mental health needs had care plans and received annual physical health check. New cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. A dementia identification scheme had been previously run at the practice The project involved screening and identified individual patients who were then invited to the practice for screening blood tests and where necessary referred to the memory clinic.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall 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 two comment cards which contained positive comments about the practice. We also spoke with six patients on the day of the inspection and three members from the patient participation group (PPG).

We reviewed the results of the national patient survey from 2015 which contained the views of 138 patients registered with the practice. The national patient survey showed patients were pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 98% of patients had confidence and trust in the last GP they saw or spoke to and 89% said the last GP they saw was good at listening to them. When asked if they had confidence and trust in the last nurse they saw or spoke to 90% agreed they had and 81% said the last nurse they saw or spoke to was good at treating them with care and concern.

The GP national patient survey reported patient satisfaction with telephone access and overall experience of making appointments was lower than other comparable practices in the area. For example, the GP national patient survey data showed that 41% of patients found it easy to get through to the practice by telephone, compared to the CCG average of 69%.

We spoke with six patients on the day of the inspection and reviewed two comment cards completed by patients in the two weeks before the inspection. The patients we spoke with and the comments we reviewed were positive. Comments about the practice included that patients felt listened to, cared for and respected. Comments also included that staff were helpful. Comments from two patients explained they had difficulties getting through to the practice in the morning but had accessed same day appointments in an emergency. Some of the patients had been registered with the practice for a number of years and told us the practice had supported all of their family members. One patient with children told us that they felt the GPs were good speaking with her children and had been able to get appointments after school times.

Areas for improvement

Action the service MUST take to improve

- Ensure that all recruitment checks are carried out and recorded as part of the staff recruitment process. Ensure there is a written risk assessment where decisions have been made regarding staff not receiving a criminal record check via the Disclosure and Barring Services (DBS)
- Ensure that an infection control audit is completed on a regular basis and any actions recorded and updated. Complete a risk assessment for the control of substances hazardous to health (COSHH) and ensure that a risk assessment for legionella is completed.

Action the service SHOULD take to improve

- Ensure that complaints information is clearly displayed.
- Improve the quality of record keeping to ensure that actions from significant events are clearly evidenced.
- Ensure there is a readily available continuity plan for staff to follow.
- Ensure that staff have a date for outstanding appraisals.
- Continue to review and implement improvements to patients' access to the practice.

Dr Evans and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a Practice Manager specialist.

Background to Dr Evans and Partners

Dr Evans and partners (also known as Fairfield Medical Centre) is situated in Leatherhead and offers general medical services to its patients. There are approximately 10,400 registered patients.

The practice is run by five partner GPs and two salaried doctors. The practice is also supported by a practice nurse and a phlebotomist. There is a team of receptionists, administrative staff, an assistant practice manager and practice manager. The practice was a training practice for GPs in training and on the day of the inspection had one GP Registrar. The practice also undertook teaching for medical students and paramedic practitioners

The practice was open from 8am to 6pm on weekdays and was closed from 12.15 for one hour. However, emergency calls were still able to be received in this time. There were extended hours on Tuesdays and Fridays with appointments available from 7am and on a Monday there were late evening appointments from 6.30pm to 8pm. Nurse appointments were also available on Monday evenings from 6.30pm to 7.30pm and phlebotomist appointments on Friday morning from 7am

Patients could book appointments up to one month in advance and the practice had a sit and wait clinic each day at 10.50. The duty doctor had appointment slots for emergency appointments between 11.30-12.30, 2pm – 3.30pm and 4pm – 5.30pm.

At the time of the inspection the registered manager who was also a partner had left the practice and a new partner had also been appointed but had not submitted the correct forms to CQC. We spoke with the practice manager in relation to this, who informed us they would submit the correct forms as a matter of urgency.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, travel advice and new patient checks.

Services are provided from:

Fairfield Medical Centre**,** Lower Road, Great Bookham, Leatherhead, Surrey, KT23 4DH

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.

The practice population has a higher number of patients between 45 and 85 years of age than the national and local CCG average, with a significantly higher proportion of patients above 65 year of age than the national average. There are a lower number of patients with a caring responsibility and the percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the average for England.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme, under the Health and Social Care

Detailed findings

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.

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 12 May 2015. During our visit we spoke with a range of staff, including GPs, nurses and administration staff.

We observed staff and patients interaction and talked with six patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed two 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)

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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. We viewed records of significant events that had occurred during the last 12 months. Significant events were discussed at the daily GP meetings as well as at the partner weekly meetings. A specific meeting for significant events was held quarterly where actions and learning points were reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. However, it was not always clearly recorded where the practice had made changes to procedures or the actions taken after discussing significant events. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used significant events / incident forms on the practice computer system. The lead GP was contacted so that they could then be reviewed and monitored. We saw records for significant event / incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, an urgent prescription request was sent in by the respiratory nurse. A prescription was accidently created for the wrong medicine and was not highlighted to the GP to review when signing. The respiratory nurse queried the new medicine and the mistake was highlighted. The patient's GP was informed and completed the correct medicine request. We saw that learning from this incident meant that the procedure was changed and that any new medicine requests need to be highlighted to the patients GP and reviewed before being signed. We saw that where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the daily meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. There was a dedicated GP lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (level 3 safeguarding children training). Staff could 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 leads were and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were accessible within the safeguarding policies.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. The practice only used GPs or nurses as chaperones. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. We saw there were posters on display within the clinical rooms and waiting area which displayed information for patients.

Requires improvement

Are services safe?

Patients' 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.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

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 clear policy for ensuring that medicines were kept at the required temperatures.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

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 as these were tracked through the practice and kept securely at all times. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have.

One of the GPs was the lead for prescribing and was also the prescribing lead for Surrey Downs Clinical Commissioning Group (CCG). The lead GP and CCG had developed a traffic light medication management system. This allowed all GPs to easily see any prescribing issues with medicines. For example, if the computer system showed a medicine as black it was not to be prescribed, green meant open prescribing, amber and red meant different grades of restriction.

Vaccines were administered by the nurse using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives and evidence that the nurse had received appropriate training to administer vaccines.

Cleanliness and infection control

We spoke with the practice manager regarding testing for legionella. The practice had not undertaken a risk assessment to minimise the risk of infection to staff and patients and did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings).

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

The practice lead for infection control had left the practice. At the time of the inspection the practice was unable to locate a recent or past infection control audit or action plans resulting from these audits. Staff told us they had received induction training about infection control specific to their role.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury. However, we noted that the practice had not completed a risk assessment for the control of substances hazardous to health (COSHH). The practice may not have identified risks associated with potentially dangerous substances or planned how to deal with any spillages of these substances. Staff may not be aware of the appropriate, and safe, way of cleaning up such a spillage.

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

Equipment

Requires improvement

Are services safe?

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We saw evidence that regular service and calibration checks on equipment were performed. We saw that fire extinguishers were serviced annually with the last one completed in March 2015.

Panic alarms were installed in all consulting and treatment rooms in case of emergency. All staff would respond if a call was raised. The practice had completed a portable appliance test (PAT) for electrical items. The practice manager informed us that they checked all cables and electrical items on a regularly basis and formally record their findings.

Staffing and recruitment

Records we looked at did not all contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, some files did not contain references from past employers, a full works history which included months and years, an investigation into gaps in employment and reasons for leaving past employers. There was also no written risk assessment as to why administration or reception staff had not received a criminal record check via the Disclosure and Barring Service (DBS). The practice had a new recruitment and selection policy that set out the standards it would follow when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including administrative staff, to cover each other's annual leave. 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 keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and health and safety information was displayed for staff to. Safety equipment such as fire extinguishers and emergency oxygen were checked and sited appropriately.

We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, we viewed meeting minutes where significant events had been discussed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. GPs we spoke with gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered double appointments when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place 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.

The practice was unable to locate an emergency and business continuity plan which would be used to deal with a range of emergencies that may impact on the daily operation of the practice. However, staff were able to tell what they would do if in the event of bad weather or power failure within the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that the fire alarm was checked weekly and emergency lighting was checked monthly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to 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. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral into secondary care. For example, suspected cancers were referred and seen within two weeks. We saw that patients received appropriate treatment and regular reviews of their condition. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those requiring end of life care. The practice provided support to patients with palliative care needs using the Gold Standards Framework. The practice worked closely with the local hospice to ensure continuity of care for patients. A dementia identification scheme had been previously run at the practice The project involved screening and identified individual patients who were invited into the practice for screening blood tests and where necessary referred to the memory clinic.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, clinical reviews and medicines management.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, audits on the use of some medicines, the number of children with asthma receiving spacer devices and patients diagnosed with heart failure being offered the pneumococcal vaccine. We saw that the practice had audited the number of inadequate cervical smear rests for several years. We saw the numbers were very low and had improved each year. The audit had also checked that where an inadequate result had been received the patient had received a follow-up test within three months.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 91% of patients with diabetes had a record of a foot examination in the preceding 12 months. We also noted that 92% of patients diagnosed with dementia had their care reviewed in a face-to-face review in the preceding 12 months. 80% of asthma patients, on the register, had an asthma review in the preceding 12 months that includes an assessment of asthma control and 97% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional, including an assessment of breathlessness in the preceding 12 months. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

Good

Are services effective?

(for example, treatment is effective)

The team was making use of clinical audit tools, and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. Patients were also highlighted on the practice computer system so that their care could be prioritised.

Effective staffing

We looked through training records for staff. Most staff had completed training in basic life support, fire awareness and safeguarding children.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff we spoke with told us they felt the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. All staff were clear on their responsibilities for passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There was a system for GPs to review results for absent colleagues.

The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. The practice worked closely with other care providers including the clinical commissioning group rapid response team. The rapid response service can provide nursing care for up to 72 hours. This nursing intervention can enable a patient to recover from an acute episode of illness and therefore avoid the need for a hospital or A&E admission. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs. The practice invited representatives from district nursing and hospice teams.

The practice hosted a number of additional services for patients within its premises. These included for example, access to a podiatrist and physiotherapy services.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made some referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record EMIS 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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found 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.

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would provide patients with information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions for example, minor surgical procedures, by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

Patients who registered with the practice were offered a health check if they were over 45 years of age or had a long term condition for which they required regular medicines. Health checks were also available with a nurse to any new patient who requested a check.

We noted a culture amongst the GPs and nurses 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 and nurses 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 noted that medical reviews took place at appropriately timed intervals. 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's performance for cervical smear uptake was 84%, which was better than others in the local clinical commissioning group area. 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 91% of children aged up to 24 months had received their mumps, measles and rubella vaccination. This was higher than the regional average. Data we reviewed showed that 70% of patients with diabetes had a flu vaccination within the six month period between September and March. There was a mechanism in place to follow up patients who did not attend screening programmes.

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

Patients completed CQC comment cards to tell us what they thought about the practice. We received two completed cards which were positive about the service experienced. Patients we spoke with said they felt the practice offered a caring service and staff were friendly, compassionate and attentive. They said staff treated them with dignity and respect.

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The report showed a mixed response with scores being either above or below the national average. For example, the national patient survey showed that 88% of patients said the GP was good at listening to them, however only 63% thought the GP was good at involving them in decisions about their care, which was below average. Only 74% of patients thought the GP was good at treating them with care and concern, however 96% of practice respondents said they had confidence in their GP.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in the consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. The treatment rooms had lockable doors and we noted that no one entered a room when the door was closed without knocking first. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Treatment and consultation rooms were only accessed by patients when with a staff member.

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The main reception area and waiting room were combined. Telephone calls were taken away from the front reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed mixed responses from patients to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 59% of practice respondents said the nurse involved them in care decisions, which was on par with the national average but 81% said the nurse treated them with care and concern and 90% said they had confidence and trusted in the nurses which were both above average. Respondents said that 82% of them felt the GP was good at explaining treatment and results and 81% said the same about the nurse, both were on par with the local clinical commissioning group area. However, only 63% thought the GP was good at involving them in decisions about their care.

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.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the information available for carers 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. Staff could also arrange a patient consultation at a flexible time and would give them advice on how to find support services.

Good

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 in the way services were delivered.

The NHS England Area Team 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.

The percentage of registered patients aged over 65 years was higher than the average for Surrey Downs clinical commissioning group (CCG) area. The practice had regular internal as well as multidisciplinary meetings to discuss patients' care and support needs. GPs explained that their current focus was on high risk older patients as they were seeking to improve their care and reduce the need for hospital attendance.

Older patients and those with long term conditions had a named GP to ensure a degree of continuity of care. One of the GPs we spoke with had recently completed diabetes training and the practice had plans to start a specialist clinic with the support of a diabetes specialist nurse from the CCG for those patients with more complex diabetes management.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the PPG had discussed with the practice having a dedicated appointment cancellation phone line for patients to call. We noted this was in place and being advertised to increase patient knowledge of its use.

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 modern purpose built premises over two floor levels. 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. Patient services were provided on the ground and first floor levels. Some independent healthcare services were provided on the second floor. A lift services were available to all floors. 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. Patients who were unable to use public transport were made aware of a community transport scheme which enabled them to request free of charge transport from their homes directly to the practice.

Access to the service

The practice was open from 8am to 6pm on weekdays and was closed from 12.15 for one hour. However, emergency call were still able to be received in this time. There was extended hours on Tuesdays and Fridays with appointments available from 7am and on a Monday there were late evening appointments from 6.30pm to 8pm. Nurse appointments were also available on Monday evenings from 6.30pm to 7.30pm and phlebotomist appointments on Friday morning from 7am

Patients could book appointments up to one month in advance and the practice had a sit and wait clinic each day at 10.50. The duty doctor had appointment slots for emergency on the day appointments between 11.30-12.30, 2pm – 3.30pm and 4pm – 5.30pm.

Patients could also book appointments on-line or request a telephone consultation. Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to three local care homes and a home for people with learning disabilities.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and

Good

Are services responsive to people's needs?

(for example, to feedback?)

how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice had received several complaints in relation to the appointment system. The most recent national patient survey recorded that only 41% of patients found it easy to get through to the surgery by phone and only 67% are satisfied with the surgery's opening hours. However, 83% said they were able to get an appointment to see or speak to someone the last time they tried and 87% said they had an appointment that was convenient. Patients we spoke with confirmed that they could see a doctor on the same day if they needed to but sometimes had difficulty in getting through to the practice in the morning. The practice manager who was new in post explained that they were currently reviewing the appointment system and phone lines in to the practice as recognition of comments from patients.

Listening and learning from concerns and complaints

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

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to. We saw that information was available to help patients understand the complaints system and the practice had a leaflet available for patients. Patients we spoke with were not aware of the process to follow if they wished to make a complaint. However, none of the patients we spoke with had ever needed to make a complaint about the practice and all said they would ask to speak with a senior member of staff and felt they would be listened to.

We looked at complaints received in the last 12 months and found these were handled, in a timely way with openness and transparency. Staff we spoke with knew how to support patients wishing to make a complaint. The practice reviewed complaints to detect themes or trends. However this was not always disseminated to all staff. We saw that lessons learned from individual complaints had been acted on.

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 vision to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose included the statement to provide the best and most appropriate patient centred healthcare services for their practice population, taking into account their diversity, needs and beliefs.

Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. They all told us they put the patients first and aimed to provide person-centred care. Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at some of these policies and procedures and found these were up to date and contained relevant information for staff to follow. This included whistleblowing, complaints, consent, chaperoning and safeguarding children.

The practice held a range of different meetings to ensure well led governance of the practice. GPs met daily and discussed any complex issues, workload or significant events or complaints. These were often addressed immediately. Monthly clinical meetings included standing agenda items on significant events, near misses, complaints and health and safety.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for prescribing and a lead for safeguarding. We spoke with 15 members of staff 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 assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for Fairfield Medical Centre were consistently above the national average. The clinical auditing system used by the GPs assisted in driving improvement. For example, audits on the use of some medicines, the number of children with asthma receiving spacer devices and patients diagnosed with heart failure being offered the pneumococcal vaccine. We saw that the practice had audited the number of inadequate cervical smear rests for several years. We saw the numbers were very low and had improved each year. The audit had also checked that where an inadequate result had been received the patient had received a follow-up test within three months.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly and there were weekly management / clinical meetings. The GP partners held monthly meetings with the senior members of staff where discussions were had on management issues including such as Quality Outcomes Framework (QOF) data and significant events.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time not just at team meetings. Staff told us that social events had been arranged by the practice. These events were used for senior staff members to thank staff for their work and provided an opportunity for reflection.

The practice manager was responsible for human resource policies and procedures. We were shown the electronic staff handbook that was available to all staff. This included sections on equality and harassment disciplinary procedures, and management of sickness, which were in place to support staff. 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

Are services well-led?

Good

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

The practice had made arrangements to seek and act on feedback from patients and staff. There was a section on the website where patients could submit comments or suggestions and the patient participation group had a suggestion / complaints box in the waiting room.

There was an active patient participation group (PPG) open to all patients. Regular meetings were held with the practice manager and a GP from the practice always attended to support the group. We spoke with two members of the PPG and they felt the practice supported them fully with their work and took on board and acted on any concerns they raised. As a result of the PPG discussions various public information sessions had been arranged for practice patients. This included a meeting to discuss the problems the practice was facing with demands for appointments and the future plans of the practice.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test, (this is an opportunity for patients to provide feedback on their experience which can be used to improve services). We saw the practice had recently introduced the Friends and Family Test and there were questionnaires available in the waiting rooms and instructions for patients on how to give feedback.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us that they had been asked to complete a questionnaire. They had been requested to provide anonymous feedback in relation to some of the work pressures they felt themselves and colleagues were experiencing and any ideas on how to improve the working environment. The feedback was then discussed at a practice meeting.

Staff we spoke with told us their regular meetings provided them with an opportunity to share information, changes or action points. They confirmed they felt involved and engaged in the running of the practice. The practice had whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Some of the staff files we reviewed contained regular appraisals however, we noted that due to the absence of the previous practice manager for some months some appraisals were now delayed. The new practice manager was aware of this and was arranging for the appraisals to take place.

The practice demonstrated its strong commitment to learning by providing opportunities for medical students and paramedic practitioners to complete training placements at the practice. The practice was also a well-established GP training practice. Three GPs had been approved as GP trainers at the practice and regularly supported GP registrars (A GP registrar is a qualified doctor who is in training to become a GP).

The management team met monthly to discuss any significant incidents that had occurred. Reviews of significant events and other incidents had been completed and shared these with relevant staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Some information (proof of identification, references, explanations of gaps in employment, full works history, reason for leaving) specified in Schedule 3 of the Health & Social Care Act 2008 in respect of people employed for the purposes of carrying on a regulated activity was not available. This was in breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and to prevent, detect and control the spread of infections due to not having regular infection control audits or assessing the risk from legionella bacteria. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.