The Shrubbery Surgery

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

A comprehensive inspection was undertaken at The Shrubbery Surgery on the 7 October 2014. The provider operated a second branch practice within the same area, that was not part of this inspection.

We found that overall, the practice offered a good level of service to all of the patient population groups who received services from the practice. Our key findings included:-

- patients felt they were treated with respect and dignity
- that staff were helpful, kind and considerate to their needs
- that their privacy and confidentiality was maintained.

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

Importantly, the provider must:

- Have processes in place for staff to follow to carry out regular checks to reduce the risk of legionella.
- Follow the practice recruitment policy to ensure all checks are in place when staff are employed.
- Review systems and processes for monitoring the quality and safety of the services provided including the completion of risk assessments following infection control audits where risks are identified and take steps to ensure all / other risks are assessed, monitored and managed appropriately.
- Follow processes for undertaking regular full clinical audit cycles to improve patient care.

In addition the provider should:

- Risk assess how emergency medicine stocks are stored.
- Risk assess the systems used for the security and control of blank prescription forms kept in computer printers.

Summary of findings

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 safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses. However, risks to patients and staff were not sufficiently assessed and minimised in relation to legionella and the condition of the flooring in the treatment areas. Some staff files did not contain sufficient documented information about the staff employed at the practice, for example, photographic ID, employment history and sufficient references. The storage and management of emergency medicines and blank prescription pads had not been risk assessed.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice completed all appraisals and personal development plans for staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others in the local area for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed and were aware of the needs of their local population and maintained links with stakeholders to plan service requirements. Patients reported good access to appointments at the practice and urgent appointments were available the same day. The practice had good 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 with staff and other stakeholders.

Summary of findings

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The practice did not have a written vision or business plan, although there was a clear leadership structure documented. Staff felt supported by management and were clear about who to go to with issues. The practice had a range of policies and procedures to govern activity and provide guidance. New staff received inductions and all staff had received regular performance reviews and appraisals. The arrangements for the management of risks was unclear, as the practice did not have an overall risk log and the risk assessments seen had not been reviewed or monitored to check actions had been taken. Governance / management meetings were held monthly and were documented, however, it was unclear about the arrangements for other staff meetings, as these were not documented to identify frequency, content or attendance. The practice had not sought on-going or regular feedback or comments from patients and the newly formed 'patient participation group' had not undertaken any patient surveys. The practice had undertaken only one clinical audit in the previous year, to monitor the quality of treatment outcomes in one area of prescribing.

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. Nationally reported data showed the practice had mainly good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. 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, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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

Summary of findings

services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with learning disabilities. The practice had carried out annual health checks and offered longer appointments if required, for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations including a mental health charity. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with nine patients and reviewed 37 comment cards completed by patients prior to our inspection. All the patients we spoke with during our inspection were very positive about the services they received from the practice. They were particularly complimentary about the staff, and said that they were always caring, supportive and sensitive to their needs. Some patients commented that they sometimes had difficulties getting through to the practice on the telephone in the mornings.

There were many positive comments from patients who had completed comment cards. All expressed a high level of satisfaction with the service they had received from the practice and about the staff. Again, some comments were made in relation to difficulties in getting through to the practice on the telephone in the mornings.

Areas for improvement

Action the service MUST take to improve

- Have processes in place for staff to follow to carry out regular checks to reduce the risk of legionella.
- Follow the practice recruitment policy to ensure all checks are in place when staff are employed.
- Review systems and processes for monitoring the quality and safety of the services provided including the completion of risk assessments following infection control audits where risks are identified and take steps to ensure all/other risks are assessed, monitored and managed appropriately.
- Follow processes for undertaking regular full clinical audit cycles to improve patient care.

Action the service SHOULD take to improve

- Risk assess how emergency medicine stocks are stored.
- Risk assess the systems used for the security and control of blank prescription forms kept in computer printers.

Outstanding practice

- The practice had historically supported patients with mental health problems by enabling them to use a separate entrance of the premises, so that they did not have to see or meet other patients if they found this difficult and might have deterred them from attending.
- The practice sent letters of condolence to all patients who had suffered a bereavement, reminding them of the support services that could be accessed via the practice.

The Shrubbery Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, and a second CQC inspector. There were no other specialist advisers on this inspection.

Background to The Shrubbery Surgery

The Shrubbery Surgery provides medical care Monday to Friday from 8.30am to 7pm, with extended opening hours on Monday and Tuesday evenings until 8pm, for patients in the Northfleet area of Gravesend in Kent. The practice provides a service for approximately 7,500 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the nursing team. There are a range of patient population groups that use the practice and the practice holds a GMS contract with the Dartford, Gravesham and Swanley area clinical commissioning group. The practice does not provide 'Out of Hours' services to its patients and information is displayed in relation to who patients need to contact when the practice is closed.

The practice has four male and one female GP partners, and one female salaried GP. There are two full-time and one part-time practice nurses, a health care assistant and phlebotomist, who undertake blood tests, blood pressure tests, ECGs, new patient checks and NHS health checks. The practice has a number of administration / reception and secretarial staff as well as a practice manager.

Why we carried out this inspection

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

How we carried out this inspection

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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the local Healthwatch, clinical commissioning group and NHS England to share what they knew. We carried out an announced visit on 7 October 2014. During our visit we spoke with a range of staff including three GPs, two practice

Detailed findings

nurses, four administration staff, the business / finance manager and the practice manager. We spoke with nine patients who used the practice and reviewed comment cards where patients and members of the public shared their views and experiences of using the practice. We also spoke with a representative from the 'patient participation group'. We observed how patients were supported by the reception staff in the waiting area before they were seen by the GPs.

The practice had a higher number of patients in older age groups than the local and national average and a higher number of patients of working age. The number of patients recognised as suffering deprivation was lower than the national average, although similar to the local average. The number of patients with long term medical conditions was slightly lower than the local and national average.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice had systems and procedures for producing risk assessments, reporting and recording incidents. There were arrangements for monitoring safety, using a range of information from audits, risk assessments and checks that were undertaken by staff. Although there was not a systematic risk log in place to monitor actions from risk assessments, the staff we spoke with were able to describe their responsibilities in relation to monitoring, reporting and recording incidents and concerns. They told us they knew the reporting procedures within the practice and were aware of the external authorities that may need to be notified if appropriate. We saw examples of incidents that had been recorded by staff, including accident records and significant event reports, and we saw significant event reports recorded and summarised for the previous three years.

Staff we spoke with described the procedure for dealing with safety alerts from outside agencies to keep the practice up-to-date with failures in equipment, processes, procedures and substances. Information was received by either the principal GP or the practice manager and was then cascaded electronically to the GPs and nursing staff to consider any follow-up actions required.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We were told by staff that systems were in place to ensure staff learned from significant events. They told us that there was an open and inclusive style of management where staff felt confident to report incidents, significant events and errors. We were told that adverse events were discussed at regular meetings, in order to review all of the significant events in a formal manner. They told us that at these meetings they discussed the incident / event, the actions taken to address issues and lessons learnt to improve the services provided.

We looked at the significant events recorded for the current year and the previous two years and saw that there were detailed reports of the incident, the actions taken, the outcome following any investigation and the date of the meetings held with staff to share and discuss learning points. We saw that changes were made within the practice as a result of incidents, for example, a new communication system had been implemented to check that urgent information had been received by the recipient, following an incident where a referral for treatment had been delayed. Significant event meetings were held at six monthly intervals, although general meeting notes were not kept and we saw that the meetings were recorded on the individual significant event report form. We saw that additional meetings were held with nursing staff when considered necessary, where urgent changes or improvements needed to be considered.

Reliable safety systems and processes including safeguarding

The practice had effective systems and processes in place, including arrangements for safeguarding vulnerable adults and children who used services. The practice had a policy for safeguarding both children and vulnerable adults and included procedures for staff guidance and contact information for referring concerns to external authorities. The policy reflected the requirements of the NHS safeguarding protocol and included a 'safeguarding governance' flow-chart and the contact details of the named lead for safeguarding within the NHS area team.

Staff told us that there was a GP within the practice who was the designated lead in overseeing safeguarding matters. GPs, nurses and administrative staff we spoke with were knowledgeable in this respect and told us they were aware of the safeguarding policy and the procedures to follow if they had to report any concerns. They told us they had received training in safeguarding vulnerable adults and children and we saw records that confirmed this. Training records for GPs demonstrated they had the necessary training to fulfil their roles in managing safeguarding issues and concerns within the practice.

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. GPs told us that they liaised regularly with social services to share information in relation to child protection concerns that were identified within the practice.

The practice had a chaperone policy. A chaperone is a person who accompanies a patient when they have an examination and 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 that this was clearly displayed for patients' information. The policy stated that only those staff that had received appropriate training would be able to chaperone patients and the staff we spoke with, as well as training records confirmed this.

Medicines Management

The practice had a policy and procedures that set out the arrangements for reviewing and issuing repeat prescriptions to patients. We spoke with members of the administration team, who told us there was a system for checking that repeat prescriptions were issued according to medicine review dates to help ensure that patients on long-term medicines were reviewed on a regular basis. Patients told us they had not experienced any difficulty in getting their repeat prescriptions, they told us that they were usually available sooner than the 48 hours specified and that the practice contacted them to attend appointments if a review was required.

We found that there was a process in place to monitor the security of prescription pads and this was in line with national guidance. For example, prescription pad numbers were recorded and monitored to ensure stock control. However, we saw that blank prescription forms were left in the computer printers in each consulting room that were not included in the monitoring process and no risk assessment had been undertaken.

We looked at the systems for managing medicines that were held in the practice for medical emergencies. We checked some of the medicines and found they were within their usable date. The emergency medicines were stored in an easily accessible box in one of the nurse's treatment rooms and these arrangements had not been risk assessed for safety. We found other medicines stored in a locked cupboard. We found that appropriate temperature checks were carried out for refrigerators used to store medicines and vaccines and records of those checks were kept. There was a protocol for maintaining the correct temperatures of vaccines received into the practice and staff were able to describe the actions they would take in the event of a failure.

We looked at the equipment used for medical emergencies and saw that single use equipment remained wrapped in its original packaging and was within usable date.

Cleanliness & Infection Control

We observed that the practice was clean and tidy. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow, for example, hand hygiene, a spillage protocol, management of sharps injuries and clinical and hazardous waste management. The policy identified a member of staff as the infection control lead for the practice and we spoke with them. They demonstrated a clear understanding of their role and responsibilities in relation to infection prevention and control. Nursing staff were aware of the protocol for sharing information and notifying the Public Health England NHS lead contact in relation to infectious outbreaks amongst patients at the practice.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. We saw that domestic and clinical waste products were segregated and clinical waste was stored appropriately and collected by a registered waste disposal company. Sharps containers were appropriately labelled, not over-filled and guidance was displayed in each treatment room for staff to follow. Cleaning schedules were used and completed by nursing staff to identify and monitor the cleaning activities undertaken on a daily, weekly and monthly basis.

Infection control audits were undertaken to monitor the cleanliness of the practice. We looked at two audits dated July and September 2014 and saw that an issue of concern had been identified in relation to the floor coverings in the clinical areas, as the surrounding edge of the floors were not covered and sealed above the skirting boards to prevent the accumulation of dirt and to aid effective cleaning. This had not been resolved through action planning or risk assessment. We also saw that the flooring in one of the treatment rooms was badly marked and damaged in places.

We saw that the premises were maintained and that service contracts were in place with specialist contractors, for example, fire safety equipment testing, electrical testing and an asbestos survey had been undertaken. However, we were told that regular checks for legionella had not been carried out at the practice and a risk assessment had not been undertaken to identify and reduce potential risks to staff, patients and others who used the premises.

All staff told us they had received training in infection control and the training records confirmed this. All the staff

we spoke with were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control. Patients told us they found the practice clean and tidy and that they had no concerns about the cleanliness of the premises.

Equipment

Clinical equipment was appropriately checked to help promote the safety of staff, patients and visitors. We were told by staff that there was a designated lead for equipment to ensure that it was routinely checked, calibrated, serviced or tested. We spoke with staff who 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 records that confirmed this, for example, records to demonstrate that medicine refrigerators were routinely checked.

Staffing & Recruitment

The practice had a recruitment policy, that reflected the arrangements for the recruitment and selection of staff. We looked at a selection of staff files and saw that appropriate criminal record checks had been carried out with the Disclosure and Barring Service (DBS), as well as professional registration checks for GPs and nursing staff. However, some staff files did not contain sufficient documented information about the staff employed at the practice, for example, photographic ID, employment history and sufficient references, as stipulated in the practice recruitment policy.

Staff told us about the arrangements for planning and monitoring staffing levels and the skill mix of staff required to meet patients' needs. We saw that the practice used a weekly rota system to plan and cover the clinical sessions to ensure there were enough staff on duty. The practice had a contract with a locum agency to cover planned and unplanned absence on the GP rota when necessary. The staff we spoke with told us that they felt there were enough staff to meet the needs of the patients on a day-to-day basis.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy and information was displayed and included in the staff handbook. Information in relation to health and safety was included in induction plans for new staff. A range of risk assessments had been completed in 2012 for the premises, for example, manual handling / lifting of inanimate objects, display screen equipment, trip hazards within the office areas and lone working. However, these had not been reviewed and updated to reflect any changes in identified risks within the practice since they had been implemented in 2012.

The practice had procedures to manage individual risks to patients in relation to deteriorating health and staff gave examples of how they monitored changing risks to different patient groups. For example, the system identified patients experiencing poor mental health, who may require urgent support and referral to the duty psychiatrist.

Arrangements to deal with emergencies and major incidents

We spoke with staff who told us about the procedure they would follow to alert other staff that they had an emergency situation in their consultation / treatment room. We were told that they would phone reception and this enabled staff to summon assistance and provide additional support if needed. We saw records that confirmed all staff within the practice had received training in basic life support and emergency resuscitation. The practice did not have medical oxygen or an automated external defibrillator (AED) for use in an emergency. However, records showed that the purchase of emergency oxygen had been discussed at a recent practice meeting. An order had been placed with a specialist supplier for an annual service contract for the supply of medical oxygen to the practice and a delivery date during October 2014 had been confirmed.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, severe bad weather that caused staff shortages, interruption to utilities, or unavailability of the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We were told by staff that the GPs in the practice held regular meetings to review and discuss updated information in relation to professional guidance, for example, National Institute for Health and Care Excellence (NICE) guidelines and other expert guidance and changes in legislation. Required changes to clinical practice were disseminated to staff and revised care / treatment plans implemented to reflect updated guidance. We were told that comprehensive and detailed patient records were kept on the electronic system and that patients who had been assessed as 'at risk', for example, older patients, had care plans in place that were reviewed with the patient and their carer every three months. Patients over the age of 75 all had a named GP who were responsible for their care and treatment.

Management, monitoring and improving outcomes for people

All staff told us that registers were kept to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions including dementia, asthma, heart disease, and diabetes. The electronic records system contained indicators to alert GPs and nursing staff to specific patient needs and any follow-up actions required, for example, medicine and treatment reviews.

We were told by GPs that data collected for the Quality and Outcomes Framework (QOF) was reviewed at clinical meetings where information was shared and discussed amongst relevant staff. Actions were agreed with regards to changes to specific treatments and therapies, in order to improve outcomes for patients. Comparisons were made in relation to national screening programmes to monitor outcomes for patients. For example, the QOF data showed that 99% of patients with diabetes had received a flu vaccination, compared to the national average of 90%.

The practice had a system for completing clinical audit cycles, although recent audits had not been completed, for example, only one clinical audit had been undertaken in 2013 to review the effectiveness of a specific medicine prescribed to a group of patients. Following the audit the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice. We were told by GPs that no other audits had been undertaken since this time and that this was the most recent audit undertaken by the practice.

Effective staffing

The practice staff team included GPs, nurses, managerial and administrative staff. We were told by staff that they had completed training in basic life support, infection control, confidentiality and safeguarding children and vulnerable adults and we saw records that confirmed this. We saw that GPs and nurses had also completed specialist clinical training appropriate to their role, for example, diabetes, asthma, family planning and updates in childhood immunisations.

We were told by staff that they received annual appraisals and informal supervision. All the staff we spoke with felt they received the on-going support, training and development they required to enable them to perform their roles effectively. We saw records that confirmed annual appraisals were undertaken for all staff. A process for GP appraisal and revalidation was in place and we saw a schedule of dates for annual appraisal and completion of revalidation for each GP within the practice.

Working with colleagues and other services

We were told by GPs and nurses that the practice had well established processes in place for multi-disciplinary working with other health care professionals and partner agencies. They told us that these processes ensured that links remained effective with health visitors, community and specialist nurses, to promote patient care, welfare and safety. For example, GPs and nurses attended quarterly meetings with the integrated care team to promote a joint approach to patient care and treatments and included specialists in mental health, palliative care and long-term conditions. Where family difficulties were identified, referrals were made into the 'Team Around the Family', who provided specialist support for mothers, babies, children and young people.

All staff told us that the practice held regular staff meetings to help ensure they were up-to-date with appropriate and relevant information, for example, clinical meetings, significant event meetings and governance / management meetings. We were told that not all practice meetings were recorded although regular discussions were held with staff within the practice. We saw that the monthly governance / management meetings were formerly recorded.

Good

Are services effective?

(for example, treatment is effective)

We were told by administrative staff that systems were in place to process urgent referrals to other care / treatment services and to ensure that test results were reviewed in a timely manner once they had been received by the practice. They described the system they used to check test results and clinical information on a daily basis and how the information was shared promptly with GPs and nursing staff as a priority.

Information Sharing

Staff told us that there were effective systems to ensure that patient information was shared with other service providers and that recognised protocols were followed. For example, there was a system to monitor patients' transition in relation to unplanned / emergency admissions to hospital. The practice received discharge notifications and these were followed-up by GPs to review and plan on-going care / treatment where required. A referral system was used to liaise with the community nurses and other health care professionals. For example, we saw that notifications in relation to birth registrations were shared with the health visitor on a monthly basis, to ensure that new mothers and babies were visited and appropriately supported.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system and told us the system worked well. The system enabled scanned paper communications, for example, those from hospital, to be saved in the patients' record for future use.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, and we saw that some elements of the legislation were included in the safeguarding training that staff received. We spoke with nursing staff who demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment. They told us that mental capacity assessments were carried out by the GPs and recorded on individual patient records. The records would indicate whether a carer or advocate was available to attend appointments with patients who required additional support. Staff told us that if they felt the patient lacked capacity to consent to treatment, they would not carry out the treatment and would request that the patient was reviewed by the GP. We saw that the practice displayed information in relation to an advocacy service in the patient waiting area, with contact details for patients and / or their carers who required independent support.

The practice had procedures for patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. We saw from the consent form in use, that there was space on the form to indicate where a patient's carer or parent / guardian had signed on the patients behalf. The process in place was clear and we were told by staff that they documented clearly the reason why written consent had not been obtained from the patient in certain circumstances.

GPs and nurses described the process for gaining consent from patients who were under 16 years of age and stated that they followed relevant guidance, demonstrating an understanding of the 'Gillick' competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

Staff told us about the process for informing patients that needed to come back to the practice for further care or treatment or to check why they had missed an appointment. We saw for example, that the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us that they were contacted by the practice to attend routine checks and follow-up appointments regarding test results.

We saw a range of information leaflets and posters in the waiting area for patients, informing them about the practice and promoting healthy lifestyles, for example, smoking cessation. Information about how to access other health care services was also displayed to help patients access the services they needed.

The practice offered a range of clinics to support patients with a variety of health care needs. We spoke with GPs and nursing staff who conducted the various clinics and they described how they explained the benefits of particular lifestyles to patients with long-term conditions such as diabetes, asthma, epilepsy and coronary heart disease. They felt that this provided patients with the knowledge and information they needed to help them manage their

Good

Are services effective?

(for example, treatment is effective)

conditions and make healthier lifestyle choices. All new patients who registered with the practice were offered a consultation with one of the nurses to assess their health care needs and identify any concerns or risk factors that would then be referred to the GPs. For example, mental health tests were offered and undertaken by nursing staff to identify risk factors associated with dementia.

The practice had systems to identify patients who required additional support and were pro-active in offering additional help. For example, vaccination clinics were promoted and held at the practice, including flu vaccination for older people. QOF data showed that 76% of patients over the age of 65 had received a seasonal flu vaccination, compared to the national average of 73%. The practice also kept a register of patients with learning disabilities and promoted / encouraged annual health checks for these patients.

The practice also offered a full range of immunisations for children and travel vaccines. Last year's performance for childhood immunisations was either in line or above average for the area CCG and there were systems in place to follow-up non-attenders.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We found that systems were in place to ensure that patients' privacy and dignity were protected at all times. Patients we spoke with and those who completed comment cards told us that they felt the staff at the practice were polite and helpful. Comments from patients were positive in relation to staff and the care and treatment that they received. The GPs and nursing staff we spoke with demonstrated how they ensured patients' privacy and dignity was maintained during both consultations and treatments. This included ensuring that curtains were used in treatment areas to provide privacy and making sure that doors to treatment / consultation rooms were kept closed when in use. From our observations, we saw that reception staff were welcoming to patients, were respectful in their manner and showed a willingness to help and support patients with their requests.

We were told by staff that the practice had a confidentiality policy, which detailed how staff should protect patients' confidentiality and personal information. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality and we saw that the policy had been shared with staff, and that they had signed individual copies to confirm they had read and were familiar with the contents.

The practice had arrangements to provide additional support for patients whose circumstances may have made them vulnerable. For example, the practice had a separate entrance that enabled patients to enter the premises without having to see or meet other patients if they found this difficult and might have deterred them from attending. If needed, home visits would also be arranged for vulnerable patients who might be reluctant to attend the practice.

The reception area was designed in a way that meant conversations on the telephone could not be heard by patients in the waiting area. We spoke with patients and were told that they felt their consultations were always conducted appropriately. We were told by staff that the practice had a chaperone policy in place that set out the arrangements for patients who wished to have a member of staff present during intimate clinical examinations or treatment. We were told by administrative staff that they had received up-to-date chaperone training. From our observations of the premises we saw notices informing patients that they could ask for a chaperone to be present during their consultation if they wished to have one.

We reviewed the most recent data from the national patient survey and saw that the practice was rated above the national average in some areas for patient satisfaction. For example, respondents who said that they could not be overheard by other patients at the reception desk and that GPs and nurses were good or very good at treating them with care and concern.

Patients we spoke with who had children told us that the practice staff treated their children with the same respect as they would when speaking with adults. They told us that the staff spoke with their child in a dignified manner and ensured they understood the care and treatment they were offered. Parents told us that staff always checked with them to make sure they had understood as well, and were agreeable to the treatment for their child.

Care planning and involvement in decisions about care and treatment

Patients were involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. We were told by the patients we spoke with that they felt listened to and included in their consultations. They told us they felt involved in the decision making process in relation to their care and treatment, that GPs and nurses took the time to listen and explained all the treatment options available to them. They said they felt able to ask questions if they had any and were able to change their mind about treatment options if they wanted to.

The patient survey information we reviewed showed patients responded positively to questions in relation to their involvement in planning and making decisions about their care and generally rated the practice well in these areas. For example, data from the national patient survey showed that 94% of patients said GPs and nurses were good or very good in involving them in decisions about their care, compared to 85% nationally. The QOF data we reviewed showed that 90% of patients had a care plan that had been agreed between the patient and their family / carer, compared to 87% nationally.

We saw a range of leaflets and posters in the waiting room to provide patients with information about health care

Good

Are services caring?

services. For example, information about the practice and the services it offered, the promotion of healthy lifestyle choices and contact details of other services and support that patients may have found useful.

We were told by staff that patients could see the GP of their choice, although they acknowledged that patients sometimes had to wait longer for an appointment if they wanted to see a specific GP.

We spoke with a patient whose first language was not English. They said that the GP was always very patient and allowed them to ask questions and always made sure that they had understood their planned care and treatment and the options available to them before they left the practice.

Patient / carer support to cope emotionally with care and treatment

We observed that staff were supportive in their manner and approach towards patients. Patients told us that they were given the time they needed to discuss their treatment and the options available to them and that they felt listened to by the GPs and other staff within the practice.

We saw that patient information leaflets, posters and notices were displayed that provided contact details for specialist groups that offered emotional and confidential support to patients and carers. For example, counselling services and a bereavement support group. The practice had a separate room available where patients could speak confidentially to any member of staff. We were told by staff that the practice sent letters of condolence to all patients who had suffered a bereavement, reminding them of the support services that could be accessed via the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found that the practice was responsive to patients' needs. The staff we spoke with explained that a range of services were available to support and meet the needs of different patient groups and that they would refer patients to specialists, consultants or clinics if appropriate. For example, referring mothers with babies and young children to the community health visitor and older people to specialist groups who supported people with dementia and associated physical problems. The practice worked closely with community nursing teams and the integrated care team who supported patients with long-term conditions and those with complex needs who received care and treatment from a range of services. Patients we spoke with told us that they were referred promptly to other services for treatment and test results were available quickly. Staff told us that the needs of different patients were always considered in planning how services would be provided, for example, arranging home visits for housebound patients. We reviewed data from the national patient survey and saw that respondents had rated the practice well in relation to the practice opening hours and getting an appointment.

We saw that the practice had begun to establish a patient participation group (PPG). An initial meeting had been held in a local community centre, attended by GPs and staff from the practice and patients who had responded to invitations to attend. We saw that a number of patients had formally signed-up to become active members of the group.

Tackling inequity and promoting equality

The premises were seen to be accessible for patients with disabilities and had accessible facilities. Wheelchairs were available on request and we saw this information clearly displayed. The practice had a hearing loop system for patients who were hard of hearing and interpretation services were available by arrangement for patients who did not speak English.

The practice took account of the needs of different patients in promoting equality, for example, people in vulnerable circumstances who had no fixed address were able to register at the practice to receive information about the help and support available to them from other services, as well as receiving care and treatment for their health care needs.

Access to the service

Appointments were available from 8am to 7pm each week day and the practice operated extended opening hours until 8pm on Monday and Tuesday evenings each week. The staff we spoke with were all knowledgeable about prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs.

We found patients could book an appointment by telephone, online or in person. Some of the patients we spoke with told us they found the telephone appointment system for booking appointments on the same day did not work very well, particularly for morning appointments. Patients said that they could either not get through during the early morning or if they did, they could not get an appointment because they had already been allocated. We looked at the patient information booklet and saw that this did inform patients that it may be difficult to get through on the telephone at certain times. However, the booklet also advised patients that if there were no appointments left, patients would be invited to leave their contact details and a GP would call them back. The GPs we spoke with confirmed that they would always ensure call backs were made to patients who had been unable to get appointments.

Patients we spoke with and comments we received all expressed confidence that urgent problems or medical emergencies would be dealt with promptly and staff would know how to prioritise appointments for them. For example, the practice had a system to identify and prioritise patients with mental health needs to ensure urgent access to mental health and psychiatric support was available on the same day if required. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment, if they needed an appointment or how the GPs would decide to support them in other ways, for example, a telephone consultation or home visit. The practice also offered pre-bookable appointments in advance, online appointment bookings and had extended opening hours on Monday and Tuesday evenings, which was particularly useful for working patients. Patients also told us they could always request

Good

Are services responsive to people's needs?

(for example, to feedback?)

longer appointments if they needed them. There was a system for patients to obtain repeat prescriptions and when we spoke with patients, they told us that they found the system worked well and their medicines were available when they needed them.

There were arrangements to ensure patients could access urgent or emergency treatment when the practice was closed. Information about the out of hours service was displayed and included in the patient information booklet and a telephone message informed patients what to do if they telephoned the practice. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The 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.

The complaints procedure was included in the practice information booklet for patients and was also displayed in the patient waiting area. We looked at eight complaints that had been received in the last year and found that these had been satisfactorily handled and dealt with in a timely way.

We saw that a complaints summary report had been produced for the year, to identify any emerging themes or trends and was discussed at practice meetings to review any changes that could be made and we saw that these were acted on. For example, a new system had been implemented to improve communication and contact with patients who were required to attend appointments following test results.

Patients we spoke with told us that they had never had cause to complain but knew there was information in the waiting room about how and who to complain to, should they wish to make a complaint.

Are services well-led?

Requires improvement

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

Our findings

Vision and Strategy

We spoke with the principle GP who told us that following a period of instability, the practice was working towards a longer term strategy, based on a 'team' approach in providing good quality care and treatment for patients. This included, for example, consideration in relation to succession planning in anticipation of future staffing arrangements for the practice. The practice did not have a written 'vision' statement or a business plan to inform individual or team objectives. However, when speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose of providing good quality care to all patients.

Governance Arrangements

The governance arrangements within the practice included the delegation of responsibilities to named GPs, for example, a lead for safeguarding, complaints and quality, and prescribing. This helped to clarify the role of each GP and provided structure for staff in knowing who to approach for support and clinical guidance. We spoke with nine members of staff and they were all clear about their roles and responsibilities and we saw documents that confirmed the roles, tasks, and activities expected of each member of staff.

Governance / management meetings were held on a regular basis to consider quality, safety and performance within the practice. This included monitoring of complaints, analysis and review of significant events. Information from the practice 'Quality and Outcomes Framework' (QOF) was reviewed to enable the practice to make comparisons to national performance and locally agreed targets. Information from clinical audits had been reviewed and actions taken to achieve potential improved outcomes for patients. However, we found that the practice had only undertaken one clinical audit in 2013 and none in 2014, to enable them to identify and consider further potential improvements to the care and treatment offered to patients and to monitor the quality of the services provided.

The practice had completed some risk assessments in relation to the premises, for example, manual handling / lifting of inanimate objects, display screen equipment, trip hazards within the office areas and lone working, although these had not been reviewed or updated since implementation in 2012. The practice did not have a risk log or a process to identify how risks were monitored and managed on an on-going basis.

Leadership, openness and transparency

We spoke with the practice GP partners and they told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. The GPs promoted shared responsibility in the working arrangements and commitment to the practice.

The staff we spoke with told us that they felt there was an 'open door' culture, that the GPs were approachable, that they felt supported and were able to approach the senior staff about any concerns they had. They said that there was a good sense of team work within the practice and communication worked well. All staff said that they felt their views and opinions were valued. They told us they were positively encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients.

There were policies and procedures in place to support staff in their roles and we saw that these were included in the staff handbook, including a whistle blowing policy and procedure. Staff social events and 'away days' had been arranged in the past to provide staff with an opportunity to reflect and focus on improvements that may benefit patients.

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

All staff told us they felt part of the team. They said that whilst there was strong leadership, the atmosphere at the practice was both open and inclusive. Staff told us that they were very happy working at the practice and felt listened to and valued. Staff were encouraged to voice their ideas and opinions about how the services were provided and managed and their suggestions were acted on. For example, changes had been made in relation to the administrative system for obtaining prescriptions, and replacement of office equipment. Staff told us they attended and participated in regular staff meetings and these included discussions about changes to procedures, clinical practice, and staff cover arrangements. However, these meetings were not recorded; we were told that only the governance / management meetings were recorded, and we saw the notes from these.

Are services well-led?

Requires improvement

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

The practice was in the early stages of establishing a PPG and had not therefore had the opportunity to use feedback and information from PPG patient surveys. We saw that the practice had undertaken its own patient survey in 2013 to seek views and comments in relation to practice opening times and the results had been considered to reach a decision. We saw that 84% of patients were satisfied with the existing opening times and changes had not therefore been made.

Management lead through learning & improvement

Records showed that GPs and nursing staff were supported to access on-going learning to improve their skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued professional development. Information and updated guidance was also disseminated from a lead nurse within the local NHS Trust to the nursing staff at the practice. Administrative staff were also supported to improve their skills and knowledge, for example, attending specific courses in relation to prescription documentation and processing. We looked at six staff files and saw that formal appraisals were undertaken for all staff, to monitor and review performance, review personal objectives and to identify training requirements.

We saw that there was a system to ensure that GPs received an annual appraisal and records showed that the GP revalidation process had been implemented at the practice.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **How the regulation was not being met:** Patients who used the practice and others were not protected against the risks associated with the spread of infection because the provider did not have suitable arrangements in place to effectively manage and monitor the risk of legionella within the service. Regulation 12 (1) (a)(b)(c), (2) (a)(c)(i).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **How the regulation was not being met:** Patients who used the practice and others were not protected against the risks associated with the recruitment of staff who may be unfit or unsuitable for their role because the provider had failed to obtain and record sufficient information about the staff they employed, such as photographic identification, employment history checks and references, as required under Schedule 3 of the HSCA 2008. Regulation 21(b).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **How the regulation was not being met:**

This section is primarily information for the provider

Compliance actions

Patients who used the practice and others were not protected against the risks of receiving inappropriate or unsafe care and treatment, because the provider did not have formal arrangements to identify, assess and manage risks, including addressing any risks identified following audits. There was no evidence of on-going, regularly completed clinical audit.

Regulation 10 (1)(a)(b), (2)(c)(ii)(e).