The Guildford Rivers Practice

Quality Report

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Date of inspection visit: 29 October 2014
Date of publication: 19/02/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of The Guildford Rivers practice on 29 October 2014. We visited the practice location at Hurst Farm Surgery, Chapel Lane, Milford, Surrey GU8 5HU.

We have rated the practice as requires improvement. Although some aspects of the practice were good, areas of improvement were required. The inspection team spoke with staff and patients and reviewed policies and procedures implemented throughout the practice. The practice was responsive to the needs of the local population and engaged effectively with other services.

Our key findings were as follows:

- There was a range of appointments to suit most patients' needs. Patients reported good access to the practice and a named GP or GP of choice, with urgent appointments available the same day.
- The practice engaged effectively with other services to ensure continuity of care for patients.
- Patient feedback showed that patients felt they were involved in making decisions about their care and were treated with kindness and respect.
- The practice had implemented an innovative approach to meeting the needs of vulnerable patients by developing an 'outreach nurse' role to visit those patients in their own homes and to coordinate all aspects of their care and support. However, risks associated with this role had not been fully assessed by the practice.

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

Importantly, the provider must:

- Ensure consistent arrangements to provide support to staff by means of appropriate supervision, appraisal and professional development.
- Introduce a process of audit of infection control processes.
- Ensure recruitment processes include all required pre-employment checks in order to minimise the risks to the health, safety and welfare of patients.

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- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the health, safety and welfare of patients and staff.

The provider should:

- Seek to gather feedback from patients via patient surveys and the establishment of a patient participation group.
- Establish a process to ensure more formal sharing of information and encourage continuous learning and improvement of all staff.
- Identify and monitor the risks associated with the role of the outreach nurse in visiting vulnerable patients within their own homes.
- Ensure a consistent approach to the use of alerts on the practice's electronic records system in order to highlight vulnerable children and adults.
- Develop a practice website to improve patient access to information relating to the practice and facilitate on line appointment bookings.

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 as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were sufficiently thorough but lessons learnt were not always communicated widely enough to ensure improvement. Risks to patients who used the practice were not always fully assessed to ensure patients were kept safe. For example the practice had not assessed the risks associated with their fire evacuation and safety procedures, the risk of exposure to legionella bacteria or the risks associated with the duties of the outreach nurse role. The practice had not undertaken a risk assessment or audit of its infection control procedures.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective as there are areas where improvements should be made. Data showed patient outcomes were at or above average for the locality. People's needs were assessed and care was planned and delivered in line with current legislation. Multidisciplinary and collaborative working was evidenced. We saw some evidence that audit was driving improvement in performance for patient outcomes. However, one staff member had not received up to date training appropriate to their role and further training needs had not always been identified and planned. Although staff reported participating in some appraisal discussions, no appraisals were recorded and personal development plans were not in place.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We 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. We found the practice had initiated positive service improvements for their patients that were often over and above their contractual obligations. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and clinical commissioning

Summary of findings

group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice. Some patients had a named GP for continuity of care and urgent appointments were available the same day. The practice premises were accessible and were well equipped to treat all patients and meet their needs. There was a well-advertised complaints process with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The practice had a clear vision and strategy. Staff were clear about the vision and their individual responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management and the GP partners. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place.

The practice had not established a patient participation group (PPG). Some feedback had been sought from specific patient groups and used to implement improvements. However, the practice had not undertaken a full survey of patient feedback across the whole practice population. Although staff told us they had participated in some appraisal discussions, these had not been recorded and personal development plans and training needs were not agreed or documented. Information sharing amongst the GPs was good but the whole practice team did not regularly attend formal meetings. However, staff told us they participated in occasional team building events. Although most staff told us there was regular informal information sharing, a lack of formal processes meant that the practice could not ensure that all staff received relevant information. A monthly staff newsletter provided some opportunity for information sharing within the team.

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 good outcomes for conditions commonly found amongst 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 rheumatology care. The practice was responsive to the needs of older patients, including offering home visits and same day appointments for those with enhanced needs. Older patients with complex care needs had personalised care plans that were shared with other services to facilitate the continuity of care.

The practice had safeguarding processes to protect vulnerable patients from abuse. Staff were aware of the process and were able to describe what action to take if they suspected abuse or had concerns. A chaperone service was available to all patients.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the population group of people with long term conditions. When needed, longer appointments and home visits were available. All of these patients had a named GP and structured annual reviews to check whether their health needs were being met. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Appropriate monitoring and reviews were undertaken to support patients with managing their conditions and preventing deterioration in their health. However, one staff member within the practice had not received training to ensure their skills and knowledge in the support of some patients with long term conditions were up to date.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments were available outside of school hours and the practice ensured that children needing an urgent appointment would be seen the same day. The premises were suitable for children and babies. There was good communication and collaboration between the practice and other services including midwives, health visitors and support organisations. Monthly meetings between the practice and the

Summary of findings

health visitor enabled them to share concerns when they arose.The practice had safeguarding processes to protect children from abuse. Staff were aware of the process and were able to describe what action to take if they suspected abuse or had concerns.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). Their needs had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. 'Walk in' access to appointments was available every day from 8.30am – 11.30am at the practice's branch surgery. Late evening appointments were available to patients on one evening per week and the lead GP provided telephone consultations on another evening each week. The practice offered online appointment booking and prescription services to meet the needs of this group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. For example, patients who were housebound or homeless. The practice held a register of patients living in vulnerable circumstances, including those with learning disabilities. However, they had not always carried out annual health checks on patients with learning difficulties. The practice offered longer appointments for patients who required them. The practice had used a risk assessment tool to enable them to identify their most vulnerable patients. These patients were provided with additional support, including home visits, by a dedicated outreach nurse. However, risks associated with this role had not been fully assessed by the practice.

Patients without a permanent address were supported by the practice. The practice's branch surgery provided support to a group of patients living in a supported housing facility and worked closely with community services to support their needs.The practice worked collaboratively with local drug and alcohol services to provide support to patients.

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.

Summary of findings

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 had a lead GP for mental health and held a register of patients experiencing poor mental health and those with learning disabilities. We saw evidence of effective collaboration and information sharing with community mental health services. Staff had received training on how to care for patients with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations.

The practice had safeguarding procedures to protect vulnerable adults, including those with poor mental health. A chaperone service was also available to all patients.

Summary of findings

What people who use the service say

We reviewed the results of the national patient survey from 2013 which contained the views of 109 patients of the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs at the practice. The survey showed that 99% of patients confirmed the last appointment they had booked was convenient to them and 89% of patients said the last GP they saw was good at explaining tests and treatments. However, the number of patients who said the last nurse they saw was good at treating them with care and concern and those who had trust and confidence in the last nurse they saw, was below the regional average.

We spoke with four patients on the day of inspection and reviewed six comment cards completed by patients in the two weeks before the inspection. The patients we spoke with and the comments we reviewed were all positive and described excellent care. All of the patients we spoke with and one comment card gave positive feedback regarding access to appointments and telephoning the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure consistent arrangements to provide support to staff by means of appropriate supervision, appraisal and professional development.
- Introduce a process of audit of infection control processes.
- Ensure recruitment processes include all required pre-employment checks in order to minimise the risks to the health, safety and welfare of patients.
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the health, safety and welfare of patients and staff.

Action the service SHOULD take to improve

- Seek to gather feedback from patients via patient surveys and the establishment of a patient participation group.
- Establish a process to ensure more formal sharing of information and encourage continuous learning and improvement of all staff.
- Identify and monitor the risks associated with the role of the outreach nurse in visiting vulnerable patients within their own homes.
- Ensure a consistent approach to the use of alerts on the practice's electronic records system in order to highlight vulnerable children and adults.
- Develop a practice website to improve patient access to information relating to the practice and facilitate on line appointment bookings.

The Guildford Rivers Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector**.** The team included a GP and a CQC Inspector.

Background to The Guildford Rivers Practice

The Guildford Rivers Practice offers primary medical services via a general medical services (GMS) contract to approximately 4,330 registered patients. The practice delivers services to a slightly higher number of patients who are aged 65 years and over, when compared with the national average. Data available to the Care Quality Commission (CQC) shows fewer of the registered patients suffering income deprivation than both the local and national average.

Care and treatment is delivered by two GP partners and three salaried GPs. There is a mix of male and female GPs. The practice employs a team of one practice nurse and an outreach nurse. GPs and nurses are supported by the practice manager and a team of reception and administration staff. The practice has not been subject to a previous inspection.

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours service.

We visited the practice location at Hurst Farm Surgery, Chapel Lane, Milford, Surrey, GU8 5HU. The Guildford Rivers Practice also operates a branch surgery at St Nicholas Surgery, Buryfields, Guildford, Surrey, GU2 4AZ. We did not visit the branch surgery as part of our inspection.

Why we carried out this inspection

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

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

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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the Guildford and Waverley clinical commissioning group (CCG). We carried out an announced visit on 29 October 2014. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

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

Detailed findings

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

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

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

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

The practice population has a slightly higher number of patients over 65 years of age than the national average. There are a lower number of patients with long term health conditions. The practice was situated in an affluent area of Surrey with lower rates of deprivation for children and older people. There were average numbers of patients who were registered as carers or who were living in nursing homes. The practice reported having small numbers of patients from vulnerable groups. For example, patients with learning disabilities or those who had no fixed abode.

Requires improvement

Are services safe?

Our findings

Safe track record

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

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

Learning and improvement from safety incidents

The practice had good systems for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months. The records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. Significant events were included on the partners meeting agenda in order to review actions from past significant events and complaints.

However, we found that details of significant events were not always shared with all relevant staff. There was evidence that appropriate learning had taken place for some but not all staff. For example, a recent significant event involved a child experiencing an asthma attack. The child had not been fast tracked when they arrived at the surgery for an urgent appointment. There was a delay in the child being seen by a GP and a delay in the GP accessing the oxygen cylinder and appropriate medication, prior to the arrival of an ambulance. This event had been recorded fully, reflected upon and appropriate learning had taken place for the majority of staff. However, a practice nurse who held a key role in the support of patients with respiratory conditions was not aware of the incident at the time of inspection. The nurse told us they had not been included in the dissemination of information and learning relating to the incident.

Staff including receptionists, administrators and nursing staff were aware of the system for raising concerns with the practice manager and GP partners. They felt encouraged to do so informally but there was no process to ensure more formal sharing of information. For example whole practice team meetings were not held, whereby concerns and events were discussed on a more formal basis.

National patient safety alerts were disseminated to practice staff on a daily basis by the GP on duty that day. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us that alerts were shared and relevant action taken. For example, the practice had responded effectively to an alert about a particular type of insulin. The duty GP had contacted all patients receiving the medication by phone and provided printed information leaflets relating to the alert. Appointments were made with patients requiring an immediate review in response to the alert.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP partner was the practice lead for safeguarding children and another GP partner was the lead for safeguarding of vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partners had undertaken training appropriate to their role. All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their role.

Staff we spoke with demonstrated a good understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. One member of staff we spoke with described a recent incident in which they had reported safeguarding concerns to the GP and the safeguarding lead. Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding was displayed in the patient waiting room and other information areas.

We reviewed individual care records and saw that alerts were not used consistently to highlight vulnerable children and adults on the practice's electronic records system. Therefore locum GPs or part-time workers who did not know individual patients well may not be alerted to potential risks associated with these vulnerable patients.

Requires improvement

Are services safe?

However, the practice nurse told us that they utilised the alert system to highlight children who had failed to attend for their immunisation appointments. This prompted other staff to act upon the missed appointment when the child and family next contacted the practice.

Systems were in place to ensure sharing of information with the local health visitor. Monthly meetings were held with the health visitor to discuss children of concern.

A chaperone policy was in place and information was clearly displayed in the waiting room, at reception and in consulting and treatment rooms. The practice manager told us that only nursing staff acted as chaperones but no training had been provided to support this.

Medicines management

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

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

There was a process for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

The practice participated in a quarterly prescribing audit and review in conjunction with the local clinical commissioning group. This enabled the practice to ensure safe and effective prescribing practices.

Cleanliness and infection control

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

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

However, the practice had not ensured they met the requirements outlined in the Department of Health Code of Practice on the Prevention and Control of Infections and Related Guidance 2010.

The practice had a lead for infection control but they had not received additional training to enable them to provide advice on the practice infection control policy or to carry out staff training. However, all staff received some induction training about infection control and undertook annual update training via an e-learning programme. The lead told us that infection control audits were not carried out within the practice and that they did not attend any practice meetings to discuss infection control processes.

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

The practice had not considered the risks associated with potential exposure to legionella bacteria which is found in some water systems. A legionella risk assessment had not been undertaken and there were no processes in place to ensure regular checks were carried out to reduce the risk of exposure to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we

saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

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

Staffing and recruitment

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. However, the practice had only one practice nurse who also covered sessions at the branch surgery. They told us that this presented difficulties at times of sickness and annual leave.

We examined the personnel records of five members of staff and found that appropriate recruitment checks had not always been undertaken prior to employment. For example, the records relating to a nurse who had been recently recruited contained no evidence that proof of identification or references had been obtained. A criminal records check via the Disclosure and Barring Service (DBS) had only been sought several weeks after the start of employment. References and proof of identification had not been obtained for another nurse who had been employed by the practice for more than two years. The practice had a recruitment policy in place but this did not accurately reflect the recruitment checks required.

Monitoring safety and responding to risk

We observed the practice environment was organised and tidy. Safety equipment such as fire extinguishers and defibrillators were checked and sited appropriately.

The practice had considered some of the risks of delivering services to patients and staff and had implemented some systems to reduce risks. We reviewed the risk assessments in place. These included assessment of risks associated with health and safety of the environment. However, risk assessments had not been carried out in relation to key areas, such as fire safety arrangements, the risk of exposure to legionella bacteria and infection control processes.

The practice had recently developed a role for an 'outreach nurse' who visited patients in their own homes. The practice had a lone working policy which supported this role and the role of GPs undertaking home visits. The outreach nurse told us they had implemented some systems to ensure their own safety when undertaking home visits. These included ensuring practice staff were aware of the address they were visiting and telephoning the practice to confirm when they had left an address. However, a full assessment of the potential risks associated with this outreach role had not been undertaken.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

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

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs attended monthly clinical meetings where new guidance, alerts and patient treatment outcome data were disseminated and discussed. Evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. However, the practice nurse did not attend these meetings and told us they relied on personal research to ensure they were up to date with current best practice guidance. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

National data showed the practice was in line with referral rates to secondary and other community care services for most conditions. The practice had recently undertaken an audit review of referrals of patients to dermatology services, following identification of referral rates slightly above the regional average. The GPs told us they used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care for with suspected cancers were referred and seen within two weeks.

One patient we spoke with on the day of inspection told us how effective the practice had been in promptly diagnosing their urgent acute condition. In addition, the GP had very quickly identified that the patient's spouse required referral to secondary care services with a suspected cancer.

Multi-disciplinary meetings were held with other health professionals to support patients receiving palliative care and their families and carers. We saw evidence of effective planning of care for patients with long term conditions and complex needs.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed the culture in the practice meant patients were referred to other services based upon need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system for completing clinical audit cycles. The practice showed us five clinical audits that had been undertaken in the last year. The GPs told us clinical audits were often linked to improving practice and treatment outcomes for patients. For example, the practice had recently undertaken an audit review of all patients who were prescribed a specific anticoagulant medicine (an anticoagulant is a medicine which stops the blood from clotting). Those patients had been surveyed to determine their preferred method of blood taking and the method used to convey the results. The same patients were surveyed again 6 months later and the management of their condition was reviewed.

Other examples of clinical audit included a review of referrals of patients to dermatology services, following identification of referral rates slightly above the regional average and a review of patients prescribed a medication to treat osteoporosis following a safety alert issued by the Medicines and Healthcare Products Regulatory Agency.

All the audits we reviewed had either been re-audited to monitor the results again after a set period of time or were planned in the next 12 months.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a national performance measurement tool.

QOF data showed that the practice performance was comparable with the national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 89.9%, with the national average being 90%.

The practice was making use of clinical meetings to assess the performance of the GPs and to update their personal learning plans. The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where these could be improved.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, safeguarding of vulnerable adults and children and fire safety. The practice had recently introduced a system which offered eLearning

Requires improvement

Are services effective?

(for example, treatment is effective)

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

Although staff we spoke with told us they had undergone annual appraisal discussions, appraisals had not been documented and only the date of appraisal had been recorded. We examined personnel files which confirmed this. One staff member described their appraisal discussion as being very brief. Staff told us that although they had the opportunity to discuss their performance, they had not had the opportunity to set objectives or formally agree learning needs as part of the appraisal process. Personal development plans were not in place for nursing and administrative staff.

The practice nurse provided support to a wide range of patients with long term conditions, such as asthma, diabetes and chronic obstructive pulmonary disorder. Although they had previously undergone some training in these areas, they told us that they had not recently received any update training. The nurse did not attend clinical meetings or have the opportunity to regularly partake in reflection and review of their performance with the GP partners. However, they told us they had recently received supervision and review of their child immunisation practices by one of the GP partners.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. All relevant 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 seeing these documents and results was responsible for updating of clinical records and other actions required. All staff we spoke with understood their roles and felt the system worked well.

The practice had a lead GP for mental health and held a register of patients with poor mental health and those with learning disabilities. We saw evidence of effective collaboration and information sharing with community mental health services.

The practice held regular multidisciplinary team meetings to discuss patients with complex needs. For example, those receiving end of life care, patients with a cancer diagnosis or those experiencing poor mental health. These meetings were attended by district nurses, social workers, community psychiatric nurses and palliative care nurses. Patients with palliative care needs were supported using the Gold Standards Framework. Decisions about care planning were documented in a shared care record. A community matron also visited the practice on a regular basis to discuss frail and elderly patients and provide support to the GPs. The outreach nurse had become involved in these multi-disciplinary meetings in order to promote effective sharing of information and continuity of care in relation to these vulnerable patients.

Patients without a permanent address were supported by the practice. The practice's branch surgery provided support to a group of patients living in a supported housing facility and worked closely with community services to support their needs.

The practice worked collaboratively with local drug and alcohol services to provide support to patients.

Information sharing

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

The practice communicated effectively with the out of hours service to ensure they received care plans and notes of vulnerable patients and those receiving end of life care. GPs within the practice provided their own telephone numbers to provide additional support out of hours for those receiving end of life care. The practice computer system enabled alerts to be added to patient records. GPs used this to highlight particularly vulnerable patients for whom the named GP could be contacted at any time.

Requires improvement

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

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

The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. However, the practice was no longer performing procedures, such as the insertion of contraceptive implants and minor surgical excisions which required the completion of written consent forms. Patients who required these services were referred to local hospital and family planning clinic services.

We found that most staff had some awareness 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. We spoke with one nurse who was not clear on the principles or its application. They told us they had not received training in dementia or the Mental Capacity Act 2005. Other staff reported that they had dementia training which briefly covered the Act. We found their understanding was limited.

GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). However, there were no written protocols to support this.

Health promotion and prevention

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions. We saw that medical reviews for those patients took place at appropriately timed intervals. Staff told us they also offered health checks with the practice nurse, to any patient who requested a check. The practice did not routinely offer new patients registering with the practice a health check.

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. However, we noted that the practice had not commenced annual checks for these patients.

The practice offered a full range of immunisations for children, some simple travel vaccines, flu and shingles vaccinations in line with current national guidance.

Patients requiring support to stop smoking were referred to the smoking cessation clinic within the local hospital.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 85% of patients rated their overall experience of the practice as good. 89% said the last GP they saw or spoke to was good at explaining tests and treatments. 82% said the last GP they saw or spoke to was good at involving them in decisions about their care.

Patients completed CQC comment cards to provide us with feedback on the practice. We received six completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were kind, efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. They all told us that they were very satisfied with the care provided by the practice and said their dignity and privacy was always respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Separate examination and treatment rooms, attached to the consulting rooms, ensured that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

The majority of staff in the practice had received some dementia training. This allowed staff to understand the needs and communication difficulties that could arise for patients with this condition. The training provided staff with the skills to identify these concerns and also support the person in alternative ways.

Care planning and involvement in decisions about care and treatment

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in decisions about their care and 89% felt the GP was good at explaining treatment and results. Both these results were higher than average in the Guildford and Waverley area.

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 very positive and aligned with these views.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 82% of respondents to the national GP patient survey said the last GP they or spoke to within the practice was good at treating them with care and concern. The patients we spoke to on

Good

Are services caring?

the day of our inspection and the comment cards we received also highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice provided extensive information to support patients and their carers to access support groups. This included a carer's resource file and information pack.

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

Longer appointments were available for patients who needed them and for those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to a local sheltered housing facility by a named GP and the outreach nurse.

The practice's outreach nurse provided home visits and ongoing support to frail, elderly patients and other vulnerable patients who were at risk of frequent accident and emergency attendances and hospital admissions. The practice had employed the use of a risk stratification tool to identify patients most in need of this level of support.

Working age patients were able to book appointments and order repeat prescriptions on line. Patients reported that repeat prescription requests were processed very quickly.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice did not have a patient participation group. Staff told us that attempts to establish a group had been unsuccessful. The practice had carried out one specific patient survey at their branch surgery in October 2014. This survey was in response to a complaint about the waiting times associated with the daily open access appointments at the branch surgery. The survey sought patients' opinions as to whether the practice should continue with this open access system and how it could be improved. The findings of the survey resulted in the practice providing a combination of open access and pre-bookable appointments and improving the comfort of the waiting area within the branch surgery.

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 told us that patients without a permanent address could register and be treated at the practice. The practice provided care and support to patients living in a supported housing facility and worked closely with community services to support their needs.

Staff told us that translation services were available for patients who did not have English as a first language. Polish and Greek speaking staff were available within the practice to assist patients.

The practice was situated in purpose built premises on one level. We noted the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toilet facilities were available for all patients of the practice.

Access to the service

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. The registered manager told us that that same day access to appointments was a fundamental offering of the practice. The practice guaranteed patients an urgent appointment within 6 working hours. Patients we spoke with and those who provided feedback on the comment cards we received, all reported being very happy with the appointment system.

Appointments were available in a variety of formats including pre-bookable appointments, urgent same-day appointments and telephone consultations. The practice was open from 8am to 6.30pm on weekdays. 'Walk in' access to appointments was available every day from 8.30am – 11.30am at the practice's branch surgery. The main surgery provided access to urgent appointments throughout the day. Late evening appointments were available to patients on one evening per week and the lead GP provided telephone consultations on another evening each week. Those patients using only the branch surgery were able to access an appointment with a female GP on one day per week. The registered manager told us this was soon to be increased to two days per week.

The practice did not have its own website but provided some minimal information to patients on opening hours and appointment availability, via the NHS Choices website. Patients could book appointments and organise repeat

Good

Are services responsive to people's needs?

(for example, to feedback?)

prescriptions via a link on the NHS Choices website. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them.

A number of comments we received from patients confirmed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. One patient we spoke with immediately prior to their appointment, told us how they often needed an urgent appointment due to a specific medical condition and they were always seen on the same day. Another patient we spoke with told us they had just visited the practice to request a flu vaccination and had been provided with an immediate appointment.

The practice had very recently developed an 'outreach nurse' role. This nurse provided home visits and ongoing support to frail, elderly patients and other vulnerable patients who were at risk of frequent accident and emergency attendances and hospital admissions. The practice had employed the use of a risk stratification tool to identify patients most in need of this level of support. This enabled such patients to access the support they needed in a timely manner.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed at weekends, after 6:30pm Monday to Friday and on bank holidays. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients on the NHS Choices website, practice leaflet and appointment information advertised in the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There were posters in the waiting room to describe the process should a patient wish to make a compliment, suggestion or complaint. Information was also advertised in the practice leaflet. A suggestion box was available to patients in the waiting area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We reviewed the practice complaints log. We found there had been three complaints within the last 12 months. The practice had investigated all the complaints and implemented appropriate actions. Learning points had been discussed in detail at meetings between the GPs and the practice manager and recorded fully. However, as the whole practice team did not meet formally, we saw no evidence to confirm that this learning had been disseminated to the other members of the team.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice was clinically well led with a core ethos to deliver the best quality clinical care in a timely manner, whilst maintaining a high level of continuity of care. This was evident from our discussions with GPs and staff. However, the practice did not have a documented overall vision and strategy.

Although the staff team understood and shared the ethos for the practice and the GP partners had agreed the vision and strategic approach of the business, we saw no evidence of documented planning which supported their decision making.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed annually and were up to date.

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

Information sharing amongst the GPs was good but the whole practice team did not regularly attend formal meetings. A series of regular meetings took place within the practice which enabled some staff to keep up to date with practice developments and facilitated communication between the GPs and the practice manager. Significant events and complaints were shared formally with the GPs at regular clinical meetings. Despite a lack of team meetings, we saw some evidence that significant events had been shared amongst the majority of the practice team to ensure they learned from them and received advice on how to avoid similar incidents in the future. However, a lack of formal processes meant that the practice could not ensure that all staff received this important information.

There were inadequate arrangements in place for identifying, recording and managing risks. We saw evidence of a health and safety risk assessment for the premises and environment. However, there was a lack of risk assessment surrounding fire safety arrangements, the control of legionella bacteria and infection control within the practice. A standard risk assessment template had been developed for lone working, for example when GPs visited patients in their own homes. However, a specific risk assessment had not been developed to reflect the role of the newly appointed 'outreach nurse' whose role presented a number of significant risks.

The practice had systems in place for completing clinical audit cycles. For example, the practice had undertaken clinical audit to review referrals of patients to dermatology services, following identification of referral rates slightly above the regional average and a review of patients prescribed a medication to treat osteoporosis following a safety alert issued by the Medicines and Healthcare Products Regulatory Agency.

Leadership, openness and transparency

GPs and staff told us about the clear leadership structure and which members of staff had lead roles. For example, there was a lead nurse for infection control and one GP partner was the lead for safeguarding children and another for the safeguarding of vulnerable adults. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. Staff mostly told us that felt valued, well supported and knew who to go to in the practice with any concerns. One staff member felt less well supported in accessing training updates and regular review of their performance.

Staff told us that there was an open culture within the practice. They had the opportunity to raise issues at any time with the GP partners and practice manager and were happy to do so. Administration and reception staff told us they did not attend any formal team meetings but that occasional social events provided the opportunity for team building. They told us that the lead GP partner regularly provided feedback and shared relevant information with the team on a casual basis. Staff valued the regular monthly newsletter which was written by the lead GP partner and circulated to all staff who were required to sign it when read. Despite the lack of meetings, all of the staff we spoke with reported that communication was good in the practice and they were always made aware of new developments and changes.

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

Are services well-led?

Requires improvement

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

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

The practice had gathered feedback from patients through comments provided via the suggestion box in the waiting area and complaints received. The practice did not have a patient participation group. Staff told us that attempts to establish a group had been unsuccessful.

The practice had carried out one specific patient survey at their branch surgery in October 2014. This survey was in response to a complaint about the waiting times associated with the daily open access appointments at the branch surgery. The survey sought patients' opinions as to whether the practice should continue with this open access system and how it could be improved. The findings of the survey resulted in the practice providing a combination of open access and pre-bookable appointments and improving the comfort of the waiting area within the branch surgery.

The practice did not regularly conduct a patient survey at the main practice and patients we spoke with confirmed that they had not been asked to provide feedback about the practice. Patients we spoke with were however, aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

A suggestion box was available to patients in the waiting area which patients were aware of.

The practice gathered feedback from staff through informal discussions. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Most staff told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

The practice had completed reviews of significant events and other incidents. These were shared amongst GPs via regular clinical meetings to ensure the practice improved outcomes for patients. Other members of the practice team were made aware of relevant significant events on a more informal basis and as a result, we found that details of significant events were not always shared with all relevant staff. For example, a practice nurse who held a key role in the support of patients with respiratory conditions was not aware of the incident at the time of inspection. The nurse told us they had not been included in the dissemination of information and learning relating to the incident.

All of the GPs within the practice had undergone training relevant to their lead roles, such as mental health and child safeguarding. All of the GPs had undergone annual appraisal and had been revalidated.

Although staff we spoke with told us they had undergone annual appraisal discussions, appraisals had not been documented and only the date of appraisal had been recorded. We examined personnel files which confirmed this. One staff member described their appraisal discussion as being very brief. Staff told us that although they had the opportunity to discuss their performance, they had not had the opportunity to set objectives or formally agree learning needs as part of the appraisal process. Personal development plans were not in place for nursing and administrative staff.

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, safeguarding of vulnerable adults and children and fire safety. The practice had recently introduced a system which offered elearning training in all the mandatory training topics for all staff. However, a practice nurse who had previously undergone some training in areas such as asthma and diabetes, told us they had not recently received updated training. The nurse told us they did not attend clinical meetings or have the opportunity to regularly partake in reflection and review of their performance with the GP partners.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

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

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

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

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The provider failed to have suitable arrangements in place to ensure the persons employed for the purposes of carrying on regulated activity were appropriately supported by means of receiving appropriate professional development, supervision or appraisal. Regulation 23 (1) (a).